



Department of Health
and Human Services

Maine People Living
Safe, Healthy and Productive Lives

**State of Maine
Department of Health and
Human Services
Office of MaineCare Services**

*State Medicaid Health Information
Technology Plan*

Final v. 2.0

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Maine SMHP Version History		
Date	Maine Document Submission	Comments
11/20/2015	SMHP v.1.0 Draft Submission to MaineCare	
12/14/2015	SMHP v. 1.1	Revisions and edits included from Jim Leonard, Amy Dix, Shaun Alfreds, Patti Chubbuck.
12/18/2015	2015 Maine SMHP Final v 2.0	Revisions included from Karynlee Harrington.

Table 1 - Maine SMHP Version History

MAINE SMHP INTRODUCTION AND EXECUTIVE SUMMARY

This document is Maine's State Medicaid Health Plan (SMHP) which serves as the "vision" for the future of the State's health information technology environment.¹ Maine's Implementation Advance Planning Document (IAPD) which is the "action plan" to implement the vision was submitted in draft form in April 2011.

Combined, the SMHP as the vision, and the IAPD as the action plan, provide the framework of the Maine Medicaid HIT program. The SMHP and IAPD should be read and understood in the context of being aligned and integrated with the broader Maine State-wide HIT initiative.

As background, America's health care system has developed from many independent networks at the local, state and national levels in both the public and private sectors. As the health care system became increasingly fragmented and costly, over the past several decades, different approaches were attempted to manage costs, integrate health care, and improve quality of care. While done with good intentions, these approaches relied heavily on paper documents and did not result in truly integrated care or full patient involvement in health care decisions. They also did not produce a system of electronic reporting mechanisms that would enable patients, the medical community, and decision-makers, to fully measure quality and to improve health outcomes.

The 2009 federal Health Information Technology for Economic and Clinical Health (HITECH) Act² brings health information technology into the 21st century. Its goals are to improve general population health, encourage better health care through the availability of comprehensive patient information, and expand patient involvement in managing their own care through the availability and use of health information technology.

The SMHP is a comprehensive document that provides a framework for the State to guide the direction of the Medicaid HIT program. At a high level, it identifies the state's vision, goals, and objectives of the Medicaid HIT program for the next five years. At the "ground" level, the SMHP provides the criteria and process for eligible hospitals and medical providers ("Eligible Professionals") to receive incentive payments to purchase, install, begin use, or improve current electronic records ("Adopt, Implement, or Upgrade") using technology that meets federal standards ("Certified"). It also lays the foundation to use the technology to improve the integration and quality of health care ("Meaningful Use"). The SMHP also describes the State's oversight functions including reporting, audit, recoupment, and fraud-prevention measures.

The SMHP serves as the vision for the future state of the Medicaid HIT environment. Its roots are found in the goals of health information exchange and meaningful use under the HITECH Act. In addition to the SMHP, Maine is submitting an IAPD which is the "action plan to implement" the SMHP.

¹ The State submitted a draft SMHP in October 2010. CMS provided written comments in December 2010 which were incorporated into a draft version 2 SMHP that was submitted in January 2011. CMS provided additional comments in April, 2011 advising the State to address the comments in a final SMHP. CMS approved Maine's SMHP on May 2, 2011. This document addresses the CMS April 2011 comments and is the final Maine SMHP.

² The HITECH Act is part of the 2009 American Recovery and Reinvestment Act (ARRA).

The body of the SMHP is divided into five Sections followed by a conclusion and appendices:³

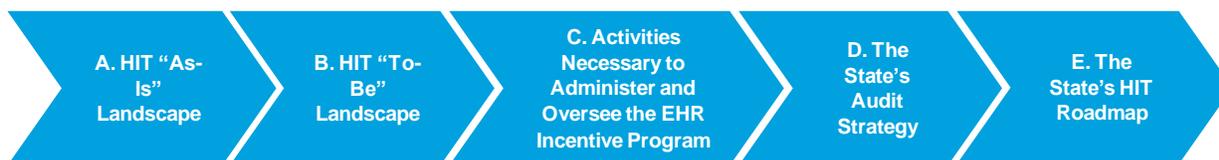


Figure 1 - SMHP Sections

SECTION A. HIT ENVIRONMENTAL SCAN “AS-IS” LANDSCAPE

The 2010 “As-Is” Landscape Assessment provided MaineCare with a baseline assessment of Health Information Technology (HIT) in Maine prior to implementation of the Meaningful Use Program. This SMHP updates that assessment for:

- An overview of the organizational structures of HIT Programs in Maine;
- The inventory and use of HIT applications and technical systems in Maine;
- Updated survey results of the status of EHR use and participation in the MU Program by provider type, and access to high speed broadband services in Maine.

In 2013, in collaboration with Maine’s State Broadband Agency, the ConnectME Authority, MaineCare conducted a comprehensive health care provider survey designed to collect information on E H R use and for the first time, tele-health and high-speed broadband use and capabilities. To view the survey:

http://www.maine.gov/connectme/grants/ntia/docs/2013_BaselineUpdate.pdf

The survey results were quite informative and will be used to further target outreach to current and potentially MU Program eligible health care providers. Moreover, the broader goals of Health Information Technology will be further enhanced by the vast amount of useful information from the survey.

SECTION B. HIT “TO-BE” LANDSCAPE

Maine’s “To-Be” Medicaid HIT Landscape for 2020 is rooted at two levels:

Visionary level: Strategic use of HIT in Maine will enable transformation of the healthcare delivery system to become patient centered, efficient and more effective. The MaineCare Meaningful Use program will support healthcare transformation by incenting providers to adopt and meaningfully use HIT, invest state and federal resources to achieve the goals of the triple aim, and develops policies that advance the state’s HIT vision and mission. The MaineCare Meaningful Use program will achieve a level of systems integration as defined by the CMS Medicaid Information Technology Architecture framework for achievement of the IHI Triple Aim.

³ See Appendices A-1, B-1, C-1, D-1, and E-1 for CMS questions posed to states to answer in their SMHP document.

Five Year Level: What the opportunities that the HITECH Act and federal and state cooperative efforts across the spectrum of HIT offer and how to best use these opportunities to build upon and improve health care access, efficiency, quality, and outcomes.

In the 2011 SMHP Maine was guided by the framework provided by the HITECH Act for improving health information technology. The structure of the programs established by the HITECH Act recognizes a federal/state partnership to build the HIT vision and to plan and implement that vision. Since 2011 the HIT environment in Maine has continued to be dynamic, with improvement in HIT technology and an increased need for transformation of healthcare delivery systems to be more responsive to value based principles and requirements of state and federal healthcare initiatives.

Collaborative strategic efforts between state and federal entities, i.e. CMS, ONC, HRSA, and NCQA, have produced many changes in policy and regulation that need to be reflected in the design, development and implementation of Medicaid systems as they relate to the Medicaid Enterprise Architecture. Updated standards have resulted in a new CMS MITA 3.0 Framework to which the state of Maine is currently pursuing a State Self-Assessment to redefine the state's business, information, and technical architectures "As-Is" and "To-Be" levels and capabilities given the advancement of HIT due the state's SIM grant activities which are described in complete detail in Section E.

The 2015 ONC vision which guides the current federal efforts is:

Vision: Health information is accessible when and where it is needed to improve and protect people's health and well-being.

Mission: Improve health, health care, and reduce costs through the use of information and technology

Maine's state-wide HIT vision, is built upon both federal and state goals and objectives, and aligned to the State Innovation Model (SIM) strategic plan. The State's vision and mission are anchored in providing and facilitating a healthcare system that is person-centered, integrated, efficient, and evidence-based, accessible to all people in Maine:

Preserving and improving the health of Maine people requires a transformed patient centered health system that uses highly secure, integrated electronic health information systems to advance access, safety, quality, and cost efficiency in the care of individual patients and populations.

The Medicaid HIT program uses these guiding principles to provide building blocks for the development of its vision and plans which have been developed with an emphasis on Maine's most vulnerable populations including children, the elderly, and disabled beneficiaries served by the MaineCare program.

Given that the overall structure of HIT vision, has changed since the submission of the 2011 SMHP due the incorporation of Meaningful Use into the SIM program, the Meaningful Use Program is overseen by the Deputy Director of Maine Care and is incorporated into the following SIM subcommittees which drive the overall vision and advancement of IT initiatives as incorporated into the statewide SIM initiative teams:

- Leadership Team
- Steering Committee
- Payment Reform Subcommittee
- Delivery System Reform Subcommittee
- Data Infrastructure Subcommittee

The Deputy Director of OMS reports to the DHHS Commissioner who in turn reports directly to the Governor. Detailed information regarding the governance of the day to day operations of the MU program can be found in this current section while a more in-depth description of SIM Governance can be found in Section E on page 210⁴.

In 2011 MaineCare initiated an environmental scan of the healthcare environment to determine the current state of health information technology adoption and use in Maine. State agencies, MaineCare providers, members of the public, Office of Information Technology, Office of State Coordinator, State finance officials, quality associations, advocates, and individuals and groups that had participated in the OSC visioning process. These sessions and the thoughtful work done by all of the participants gave MaineCare an understanding of a common vision for the Medicaid HIT program in concert with other State-wide health information technology efforts and under the rubric of the OSC developed State HIT plan. This vision still holds true today and is incorporated into all aspects of the Medicaid program as we advance HIT to improve patient care access and delivery:

A Medicaid program that employs secure electronic health information technology to provide truly integrated, efficient, and high quality health care to MaineCare Members, and to improve health outcomes.

SECTION C. ACTIVITIES NECESSARY TO ADMINISTER THE EHR INCENTIVE PROGRAM

The Medicaid HIT program provides many benefits to MaineCare beneficiaries, healthcare providers, and those developing health policies. The program also presents challenges, which come from the complexities associated with planning and implementing a complex program using new technology. Over the past five years, MaineCare has developed processes and activities necessary to effectively administer the Medicaid HIT Program. The program has used the CMS framework provided to states for developing its “necessary activities” section of the SMHP: 1) Program Registration and Eligibility; 2) Payment; 3) Appeals; 4) Reporting; 5) Communication, Education and Outreach; and 6) State Oversight. MaineCare developed a step-

⁴ Hyperlinked cross-reference

by-step process flow to identify each activity needed to meet EHR program technology and operations requirements and then for each activity, identified specific tasks and technologies.

SECTION D. AUDIT, CONTROLS AND OVERSIGHT STRATEGIC PLAN

Maine understands and respects the importance of oversight of the HIT program. MaineCare conducted a thorough examination of the Federal oversight requirements for Medicaid HIT programs which it used to develop its audit, controls, and oversight processes and requirements. Maine is using a risk-based auditing approach to help ensure program integrity, prevent making improper incentive payments, monitor the program for potential fraud, waste, and abuse, and recoupment procedures. In previous years the Audit Strategy was included within the SMHP document, per CMS guidance as a best practice Maine will be submitting it's updated 2015 Audit Strategy in a separate document.

SECTION E. GAP ANALYSIS AND HIT ROADMAP

Maine compared its “As-Is” current-state with the “To-Be” future-state to identify what the State needs to do to plan and implement a successful Medicaid HIT Program. “Success” can only be met if the State makes progress towards both the EHR incentive payment effort and the long-term HIT vision. The results of the gap analysis were fed into the HIT Roadmap and the Activities sections of the SMHP.

CONCLUSION AND APPENDICES

The SMHP concludes with a summary and appendices that supplement and provide more detail in support of the State Medicaid Health Plan.

SECTION A. AS-IS

The 2010 “As-Is” Landscape Assessment provided MaineCare with a baseline understanding of Health Information Technology (HIT) in Maine prior to implementation of the Meaningful Use Program. This SMHP updates that assessment for State Level HIT Governance and Organization and Inventory and use of HIT technical systems and assets in Maine. Using information provided in 2013 from a jointly developed environmental scan, MaineCare has been able to expand upon its’ outreach efforts to both current and potential providers for the MU Program. The evaluation of the Health Information Exchange (HIE) by HealthTech Solutions (4/24/2014) provided the program with an understanding of the state’s HIE capabilities and supports to the broader health information system. The State Innovation Model planning phase (4/1/13 – 9/30/13) informed the Health Information Technology strategies in the state to achieve transformation in Maine’s healthcare delivery and payment structures (see SIM operational plan for details).

Section A. Part 1. State Level HIT Governance.

In 2010, under the HITECH Act a four year cooperative agreement was established between the Office of the National Coordinator (ONC) and the state of Maine to establish a governance structure to develop HIT policies and implement a statewide health information exchange

(Maine's 2010 health Information Technology Strategic Plan). The governance structure, Maine's Office of the State Coordinator (OSC), included stakeholders from the legislature, healthcare providers, advocacy groups, consumers, and government entities. The governance model was built around an executive steering committee and standing committees which advised the OSC on HIT issues. This four-year time period enabled Maine to build and implement a sustainable HIT governance structure in which the OSC governance structure has been assimilated into the overall DHHS governance structure in the form of a multi-stakeholder governance operated under Maine's State Innovation Model (SIM). A SIM sub-committee focused on data and infrastructure, led by the state's health information exchange was developed to further identify health information gaps affecting value based purchasing strategies. The umbrella of the State's VBP governance structure includes Maine's State Innovation Model (SIM), Health Homes Program, Accountable Communities, with the Meaningful Use Program transitioning to truly integrating with emerging initiatives that fully promote the Triple Aim. A more detailed discussion of the new HIT organizational framework as it relates to these state-wide initiatives can be found in SECTION E of the SMHP page 210.⁵

Maine's Meaningful Use Program transitioned from the Governor's Office to the Maine Department of Health and Human Services. The organizational structure is shown below:

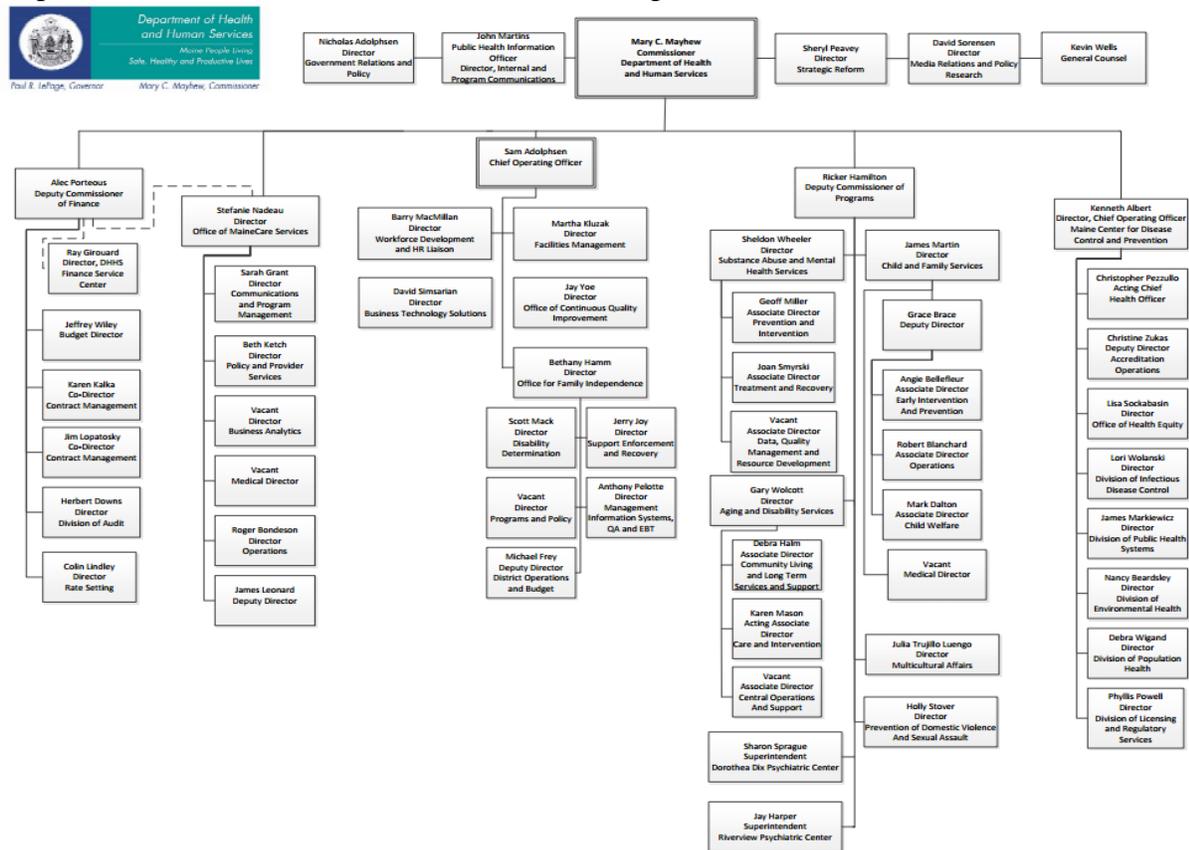


Figure 2 – Maine Department of Health and Human Services Organizational Chart

⁵ Hyperlinked cross-reference

A1a. Commissioner’s Office

The Department of Health and Human Services is led by a Commissioner appointed by the Governor of Maine, and confirmed by the Maine State Senate. The Commissioner is responsible for oversight of all DHHS Offices, financial management, Maine’s Center for Disease Control, Medicaid (MaineCare), and policy.

A1b. Office of Maine Care Services

The Office of MaineCare Services (OMS) has oversight of Maine’s Medicaid Program (MaineCare), Maine Eye Care, Maine Rx Plus, Drugs for the Elderly and Disabled, Data Analytics, and the MaineCare Meaningful Use Program.

The following organizational chart depicts the OMS management structure:

**MaineCare
Office Structure**

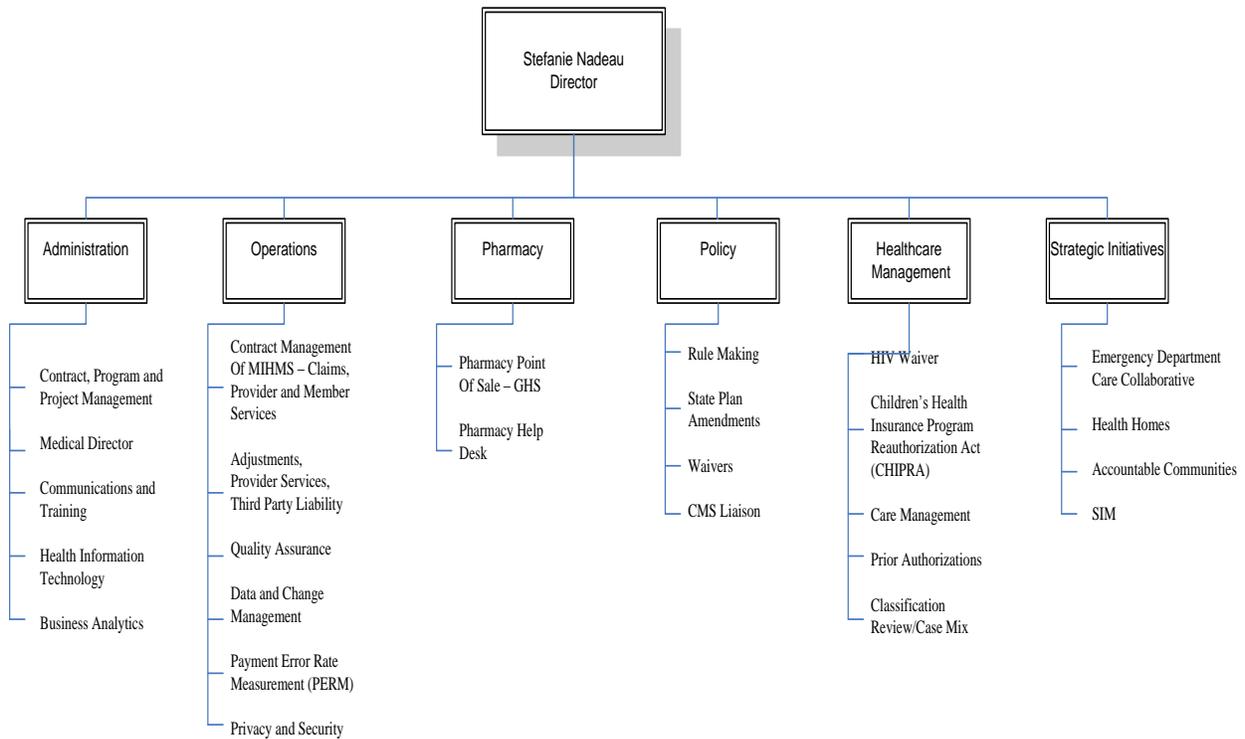


Figure 3- MaineCare Organizational Chart

- **Administration:** The Office of Maine Care Services is led by the Medicaid Director who manages the administration of the Administrative Senior Management Team who has program and operations oversight for operations, policy, and data analytics. MaineCare’s

Deputy Medicaid Director has responsibility for Health Information Technology (HIT) initiatives, including the MaineCare Meaningful Use Program whose Program Director reports directly to the Deputy Director. This structure ensures that HIT and the MU Program are fully integrated into the administration of Medicaid initiatives.

- *The Operations Division* manages claim submission and processing, quality assurance, data analytics and privacy. The fiscal agent, Molina, performs claims processing, payment, and reporting functions using the MIHMS system. (See Section A4c1 on page 34⁶ for more detail.)
- *Third Party Liability (TPL)* coordinates the avoidance of MaineCare costs through paying private insurance premiums when cost-effective; a COBRA-like insurance for some children; and estate recovery. The fiscal agent supports this function by hosting a database that contains information related to other insurance coverage available to MaineCare Members.
- *Customer Services* interacts with MaineCare providers to process provider enrollments, provide information and training, and answer questions related to policy, billing, claims status, and other payment issues. The fiscal agent supports this function through help desk and call tracking workflow, and an Automated Voice Response System (AVRS).
- *Health Care Management* oversees and manages services provided to MaineCare Members including the MaineCare Pharmacy program; prior authorizations; and care management. A fiscal agent supports this function by processing pharmaceutical rebates.
- *The Data Analytics* unit provides claims and health care data gathering and analysis for tracking services, expenditures, quality assurance, trending, and forecasting.
- *Privacy and Security* of all data, but especially, Protected Health Information (PHI) is at the forefront of all actions and activities at MaineCare Services. The Privacy and Security Officer for MaineCare is a member of the Department's Privacy Strategy Team discussed above.
- *The Policy Division* promulgates rules for MaineCare, oversees State Plan Amendments, and coordinates legislative activities. The Policy Division promulgated the MU Program rules which referred and deferred to CMS rules and where appropriate, provided Maine-specific rules for the MU Program.

A1c. Finance-Audit

The Department's finance division is responsible for preparing and submitting DHHS-wide budgets for federal and State funding, and for accurately and timely tracking expenses ensuring that all expenditures comply with Federal and State laws.

The Finance Division also includes the Department's audit services:

⁶ Hyperlinked Cross-reference

- MaineCare Audit – conducts cost settlement reviews on MaineCare providers receiving reimbursement on a cost basis such as Nursing Facilities, Hospitals, Residential Care Facilities, Private Non-Medical Institutions and Intermediate Care Facilities for the Mentally Retarded (ICF/MR);
- Social Service Audit– conducts desk reviews on A-133 audits submitted by community agencies as well as close-out reviews on all Department contracts to sub-recipients;
- Internal Audit – oversees all auditing of DHHS conducted by external agencies, assures corrective action plans are implemented and meeting their objective and conducts specialized audits as needed;
- Program Integrity – oversees payments under MaineCare for non-cost settled programs, conducts post payment reviews to prevent/limit fraud, waste, and abuse and to recoup funds when appropriate (including the MU Program); and
- Rate Setting – sets reimbursement levels and oversees all rate setting activities.

From 2011 until early 2014, the audit division was responsible for conducting pre- and post-payment audits for the MU Program. Beginning in May 2014, the audit function was transferred to a vendor. (See Section D: State Audit Strategy for more details on the MU Program audit process.)

A1d. Operations and Programs

A1d1. Office of Continuous Quality Improvement (OCQI) supports and enhances the quality and integrity of services provided to the people DHHS serves. OQI emphasizes consumer and family involvement, building strong relationships with internal and external stakeholders, and the use of outcome measurements to guide policy and decision-making.

A1d2. Office of Family Independence determines eligibility for all entitlement programs, collects child support, assists with disability determination; and TANF and the Food Supplement Program.

A1d3. Office of Adult Mental Health Services oversees programs for Maine adults with mental health needs, including community services, hospital services, and consumer-directed services to eligible adults and members.

A1d4. Office of Adults with Cognitive and Physical Disability Services oversees programs for Maine adults with mental retardation or autism and adult developmental services, brain injury services, and physical disability services.

A1d5. Office of Child and Family Services oversees programs for eligible children including behavioral health programs, child welfare services, and early childhood programs.

A1d6. Division of Elder Services oversees three program areas: Elder Services Community Programs, Long-Term Care Services and Supports, and Adult Protective Services. Some of the services funded by MaineCare include Adult Day Health Services, Adult Family Care Homes, Home and Community-Based Waiver Services, Home Health Services, Home-

Based Care, Hospice Services, Nursing Facilities, Private Duty Nursing/Personal Care Services, and Residential Care Services.

A1d7. Office of Substance Abuse oversees substance abuse prevention, intervention, education and treatment.

A1d8. Maine Center for Disease Control and Prevention (Maine CDC)
CDC is Maine's public health agency that monitors and reports on the health status of the population, and addresses emerging health concerns:

- The Chronic Disease Division tracks, prevents and reduces the impact of major chronic diseases using an ecological approach that considers individuals within the social, organizational, and environmental contexts in which they live. Programs include: the Partnership for a TobaccoFree Maine, Healthy Maine Partnerships, Comprehensive Cancer, Physical Activity and Nutrition, Diabetes, Breast and Cervical Health, Oral Health, Cardiovascular Disease, and Coordinated School Health.
- Environmental Public Health protects people from environmental hazards through public health strategies such as Safe Drinking Water, Health Inspection, Environmental and Occupational Health, Wastewater, and Radiation Control.
- Family Health uses population-based public health strategies to address the health of certain segments of the population. Programs include: Public Health Nursing; Early and Periodic Screening, Diagnostic and Testing Services; Injury Prevention; WIC; Genetics and Newborn Screening; Women's Health; and Teen and Young Adult Health.
- Infectious Disease focuses on preventing and controlling infectious diseases. Programs include: Immunization; Epidemiology; and HIV, STD, and Viral Hepatitis.
- Public Health Systems provide some of the cross-cutting and foundational public health functions. Programs include: Health and Environmental Testing Laboratory, Vital Records and Vital Statistics, Public Health Emergency Preparedness and Public Health Informatics.

The federal requirements for the Meaningful Use program requires EHs and EPs to submit specialty registry information to a state's CDC. Maine's CDC and MU Program are integrating the registration and attestation process for EHs and EPs which includes the onboarding to the CDC specialty registries. See Appendix C-4 page 297 for more details regarding the onboarding process.

A1d9. Office of Information Technology (OIT) is within the Department of Administrative and Financial Services. OIT has a group of staff dedicated to DHHS which includes staff dedicated specifically to the MU Program. OIT is responsible for the delivery of

safe, secure and high performing networks and systems to State agencies for daily performance of their missions. OIT plays a key role in supporting the technical needs of MaineCare and DHHS programs by providing and supporting IT systems that enable programs to meet the needs of the state. For the MU Program, OIT developed an IT solution to collect and report MU program information. OIT also and provides ongoing operational support for the technical solutions used by the MU Program and provider users. This also includes all automated interfaces, file transfers and processing between the States MU program SLR, various State agencies and CMS's NLR. Please see Section C page 70⁷ for more detail.

Section A Part 2. Use of EHRs and HIT by the Numbers

A2a. 2010 Baseline Survey

In 2010, MaineCare commissioned a survey of health care providers which functioned as a baseline assessment for the incentive payment Program. The 2010 Survey found that only 49% of medical practices and 80% of hospitals had implemented EHR systems in all or most of their departments or areas. EHR adoption varied greatly by Medical practice size and type. For example, 66% of 96 large practices had adopted and implemented EHR technology in their practice; 58% of the 120 medium size practices; with only 32% of the 180 small practices adopted and implemented EHR technology in their practice.

Of the 210 Medical practice sites that had not adopted or implemented EHR technology, 70% plan to adopt and implement EHR technology in the next five years.

Based on these data, 63 Medical practices (including eligible providers) practice sites without an EHR had no plans to adopt or implement EHR technology within the next five years.

Medical practices (including eligible providers) practices that currently do not have EHR technology identified that the primary barrier was the cost to acquire EHR technology; second was cost to maintain EHR technology; and the third was a mix of return on investment concerns and internal knowledge/technical resources barriers.

Nearly all of the hospitals reported that a majority of clinical staff use the EHR routinely with 66 percent reporting over 90 percent, and 28 percent reporting between 51 and 90 percent. Nearly three-quarters of the hospitals reported that a majority of providers use the EHR system routinely. Another 14 percent reported that between 25 and 50 percent of providers use the EHR system routinely and another 14 percent reported that fewer than 25 percent of all providers use the EHR system routinely. One of the hospitals reported no longer using paper charts; 34 percent reported that they maintain paper charts, but that the EHR is the most accurate, complete source of patient information; 59 percent use a mix of paper and electronic information; and one hospital primarily uses paper charts, but maintains electronic records for some clinical information.

Dental practices were also surveyed. A challenge for dental practices is that almost one-half of dental practices in Maine reported that they were small solo practices. In addition, although 70% of the dental practices had an E H R, the dental E H R was not "certified" under meaningful use

⁷ Hyperlinked Cross-Reference

requirements. Instead, dentists used practice management systems (PMS) or electronic dental records (EDR) which are geared toward dental services.

Based on the initial 2010 survey, Maine predicted that about 300 providers would be “eligible professionals.” In mid-2010, legislation about the hospital-based professional, changes to the application process, such as the proxy amount for the cost of EHRs, and further discussions with provider associations, led Maine to believe that the estimate could be as high as 1,000 EPs. (Note: To date, the actual participation rate of Eligible Professionals exceeds 2,500 EPs.)

A2b. 2013/2014 Broadband/HIT Collaborative Survey

In 2013, in collaboration with Maine’s State Broadband Agency, the ConnectME Authority and MaineCare jointly conducted a comprehensive health care provider survey designed to collect information on EHR use and for the first time, tele-health and high-speed broadband use and capabilities in Maine. To view the survey:

http://www.maine.gov/connectme/grants/ntia/docs/2013_BaselineUpdate.pdf

The survey results were quite informative and are being used to further target outreach to current and potential MU Program eligible health care providers. Moreover, the broader goals of Health Information Technology will be further enhanced by the vast amount of useful information from the survey.

Availability of Broadband. The 2013 survey results show that 98 percent of surveyed healthcare facilities have access to the internet, an increase of 8 percentage points since 2011. The survey showed that 95 percent of surveyed organizations have access to broadband, an increase of 7 percentage points since 2011. In terms of specific broadband technologies, 61 percent have access to cable, 53 percent to DSL, 34 percent to fiber optic, and 32 percent to T-1. The availability of mobile wireless—whether at broadband speeds or not—is also relatively high at 30 percent.

Use. 79 percent of respondent health organizations exhibit heavy computer use (68% almost all of the time; 11% most of the day, almost every day). Only 1 percent indicated they had not used the computer at all in the previous week, and 2 percent indicated that they had no computer at the practice location.

The percentage of respondents that use some form of broadband is relatively high at 95 percent. In terms of specific broadband technologies, 43 percent connect to cable, 29 percent to DSL, and 22 percent to T-1. Only 4 percent use fiber optic or fixed wireless technologies. 12 percent use mobile devices to connect.

The percentage of healthcare organizations that have no internet connection and would like to connect is a high 46%.

Similar to businesses, healthcare organizations connect to the internet first and foremost to conduct basic communications (98%) and office functions, such as recordkeeping (74%) and managing finances and billing (67%). Other major reasons to connect are to provide or access training online (77%) and to conduct the healthcare practice (63%). The percentages of

respondents who use the internet to participate in the HealthInfoNet Health Information Exchange (HIE) was found to be 22%; to provide telemedicine services was 13%; and transmit medical imagery was also 13%.

With faster internet, the largest percentage of respondents indicated that they would do more telemedicine/telehealth (32%), recordkeeping (24%), and online training (23%).

Drivers. The availability of new online healthcare technologies, such as electronic health records (EHRs), e-prescribing, and telemedicine systems, are major drivers of high-capacity broadband connectivity among Maine's healthcare organizations.

One-third of the 2013 survey respondents are connected to the HIE, although most have read-only (82%) rather than interactive access for data exchange. 64 percent of respondents have installed and use an EHR system, and of that 64 percent, over 80 percent use the system heavily. Of those respondents that use an EHR system less than 50 percent of the time, almost half (47%) indicated that they are still in the process of implementing such a system. In comparison with EHR systems, respondents' use of e-prescribing (27%) and telemedicine systems (7%), additional drivers of broadband adoption, is relatively low. It is important to note that the largest percentage of respondents (32%) indicated they would do more telemedicine if they had faster internet.

Barriers. Although the Maine healthcare community has made meaningful gains since 2011 in using broadband to deliver services, barriers still exist in the adoption of internet and specific health information technologies that improve patient care and drive broadband adoption. As with other consumer groups, lack of awareness of broadband's benefits (including federal payment incentives), access to adequate service, and perceived value for the cost continue to be the biggest barriers. Lack of IT support in small practices also continues to be a barrier, although a significant percentage (66%) of 2013 respondents indicated that they have an employee dedicated to IT duties.

The 2013 survey of health organizations updates our knowledge and provides new findings on computer and internet use and broadband subscribership of this key consumer group.⁸

Over half (64.2%) of the practices have multiple locations with 34.7 percent practicing at a single location within Maine. Many of the respondent organizations are longstanding: 72.2

⁸ The 2010 survey findings were based on data from an existing 2010 Health Information Survey conducted by the Muskie School Cutler Institute for Health and Social Policy, University of Southern Maine, for the OSC. The 2013 survey results are based on an expanded email and online questionnaire and reflects a sample of 513 healthcare facility locations, out of a total number of 3,135 survey recipients. The 2013 survey sample comprises a range of healthcare organizations, from behavioral health facilities (the majority at 52.0%) to long-term care facilities (12.2%), ambulatory healthcare facilities (8.6%), dental facilities (4.9%), federally qualified health centers (FQHCs) or rural health clinics (RHCs) (4.9%), and home health agencies (4.0%). As respondents to the survey were focused on long term care and behavioral health, the results will be different from the 2010 survey which was comprised of health care practices.

percent have been in practice for over a decade, with 30.7 percent over 30 years. The largest percentage of organizations are small, with less than 5 employees (28.2%); 19.5 percent have 20 to 50 employees. Only 10.8 percent of respondents have over 100 employees.

Availability. 2013 survey results show that 98 percent of surveyed healthcare facilities have access to the internet, an increase of 8 percentage points since 2011. However, having internet access does not mean that the level of internet access needed to perform activities such as telehealth or sending images, is adequate for those types of services. In late 2014, the ConnectME Authority, based on changes to FCC rules, modified what it considered to be “high-speed.” The Authority moved from a 1.5 Mbps down to 10 Mbps up and down, which is capable of carrying high image and data files, which are needed for newer and more sophisticated health care delivery. The change resulted in the recalculation of access to be reduced from 98% to 26%, which demonstrates the need for additional resources and efforts at improving high speed internet services.

Computer and internet use. 79 percent of respondent health organizations exhibit heavy computer use (68% almost all of the time; 11% most of the day, almost every day). Only 1 percent indicated they had not used the computer at all in the previous week, and 2 percent indicated that they had no computer at the practice location.

Significantly, the largest percentage of respondents indicated that they would do more telemedicine/telehealth (32%) if they had faster internet. They also cited recordkeeping (24%), and online training (23%) as important. Fewer respondents indicated they would connect with other offices of the same practice (19%) or with other practices (17%), participate in the health information exchange (14%) and transmit medical imagery (7%).

Drivers of computer and internet use. A major driver of high-capacity broadband connectivity is Maine’s HIE, a secure, interoperable network for centralizing and sharing healthcare information with healthcare organizations, providers, public health agencies and consumers statewide.⁹ Administered through Maine’s HealthInfoNet, a public-private nonprofit organization, and supported by federal grant monies under the Health Information Technology for Economic and Clinical Health Act, the network currently connects 35 out of 38 Maine hospitals and many of Maine’s healthcare facilities. One-third of the 2013 survey respondents are connected.¹⁰ The highest percentage of participation is shown among FQHCs or RHCs (57.1%), behavioral health facilities (51.4%), ambulatory healthcare facilities (45.9%), and those facilities that are affiliated with a hospital (73.7%) or part of an FQHC or RHC (60.0%).

Of those respondents that are connected to the HIE, the largest percentage (82%) have read-only rather than interactive access for data exchange. Behavioral health facilities indicate they have read-only access, whereas FQHCs or RHCs (72.7%) and ambulatory healthcare facilities (64.7%) are most likely to interact fully with the system.

⁹ <http://www.hinfont.org/about-us>

¹⁰ Note that connection to the HIE does not necessarily mean use of it; in response to a different question, only 22 percent cited they used the system.

Other major drivers to broadband subscribership in the healthcare industry are the availability of EHR, e-prescribing, and telemedicine systems that improve patient care. HealthInfoNet, which also serves as the Maine Regional Extension Center,¹¹ helps Maine primary care providers and critical access and rural hospitals adopt and effectively use certified EHRs and e-prescribing technologies. The “meaningful use” of EHRs is also incentivized through the Centers for Medicare and Medicaid Services (CMS) EHR Incentive Programs, which make 100 percent federally funded payments to eligible professionals and hospitals for adopting, implementing, upgrading, and demonstrating meaningful use of the technology.¹²

Healthcare Organizations Use of EHRs	
Use of Electronic Health Records (EHRs)	% of Respondents-- 2013
EHR installed and in use	64%
Frequency of EHR use:	
• Almost all of the time (100%)	65%
• Most of the time (75%)	16%
• Part of the day (50%)	7%
• Occasionally (25%)	2%
• Rarely (10%)	9%
• Not at all (0%)	1%
Reasons for less than 50% use:	
• Currently implementing EHR	47%
• Too many clicks	5%
• No patient summary snapshot	5%
Reasons for no EHR system:	
• Funding/costs	59%
• Not needed	32%
• Too complicated	13%
• Plan to close/sell practice in 3-5 years	6%
• Lack of access to required internet speeds	2%
Awareness of Medicaid/Medicare EHR incentive payment program:	55%
• Aware	45%
• Not aware	
Participation in EHR incentive program:	
• No	65%
• Yes	17%
• Don't know	18%
Number of professionals participating in EHR incentive program:	48%
• 1-3	21%
• 4-7	6%

¹¹ <http://www.hinfonyet.org/providers/maine-regional-extension-center>

¹² <http://www.maine.gov/dhhs/oms/HIT/>

<ul style="list-style-type: none"> • 8-11 • 12-15 • 16 and over 	<p>9%</p> <p>16%</p>
Reasons for lack of participation in EHR incentive program: <ul style="list-style-type: none"> • Behavioral health care facility—do not qualify • Unaware of the Meaningful Use Program • Do not employ type of professionals who are eligible • Long term care facility—do not qualify • Do not serve enough Medicare/Medicaid patients to qualify 	<p>43%</p> <p>39%</p> <p>7%</p> <p>7%</p> <p>4%</p>

Table 2 - Healthcare Organizations Use of EHRs

The low percentage of participation in a Meaningful Use Program is not surprising, given the make-up of the survey respondents. Many respondents were not eligible providers such as long term care and behavioral health organizations. When the survey results are compared with the actual number of percentages of potentially eligible professionals, participation in a MU Program jumps to over 76%.

In comparison with EHR systems, respondents’ use of e-prescribing (27%) and telemedicine systems (7%), additional drivers of broadband adoption, is relatively low).¹³ Results show that the use of e-prescribing is more likely among ambulatory healthcare facilities (83.8% use e-prescribing), FQHCs or RHCs (85.7%) or organizations that are part of an FQHC or RHC (80.0%) or affiliated with hospitals (42.1%). FQHC or RHC respondents or those organizations affiliated with FQHC or RHCs are most likely to provide telemedicine services (19.1% and 20.0% respectively).

It is important to note that the largest percentage of respondents (32%) indicated they would do more telemedicine if they had faster internet.

Barriers to computer and internet use. Although the Maine healthcare community has made meaningful gains since 2011 in using broadband to deliver services, barriers still exist in the adoption of internet and broadband-driven HIT to improve patient care. As with other consumer groups, lack of awareness of broadband’s benefits (including federal payment incentives), access to adequate service, and perceived value for the cost continue to be the biggest barriers. Lack of IT support in small practices also continues to be a barrier, although a significant percentage (66%) of 2013 respondents indicated that they have an employee dedicated to IT duties.

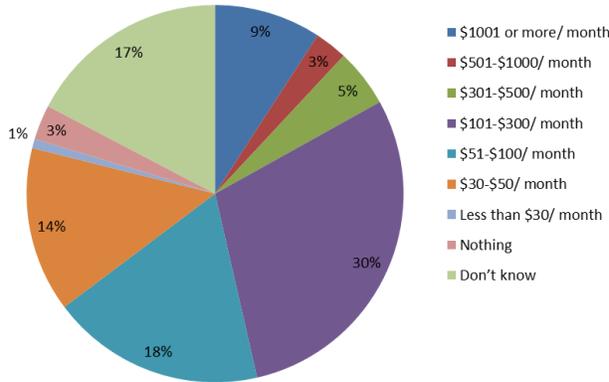
¹³ From 2011 to 2013, the use of telemedicine dropped from 18 to 7 percent, in large part due to differences in measurement criteria between the 2011 Muskie School study and this update. The update focuses on the use of high-speed internet for delivering telemedicine services, whereas the Muskie School examined the use of telecommunications—telephones, e-mail, videos—to provide diagnosis, treatment, education and other healthcare activities, a somewhat broader focus.

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ange and a third in

Figure 4 - Internet per

Cost awareness also of access to 2013 is the major

system perceived need second (32%)



Healthcare Organizations Cost of Month

concerns and lack of of broadband benefits are barriers to respondents' use applications that require high-speed internet services. survey findings indicate cost reason respondents have not implemented an EHR (59%), with lack of

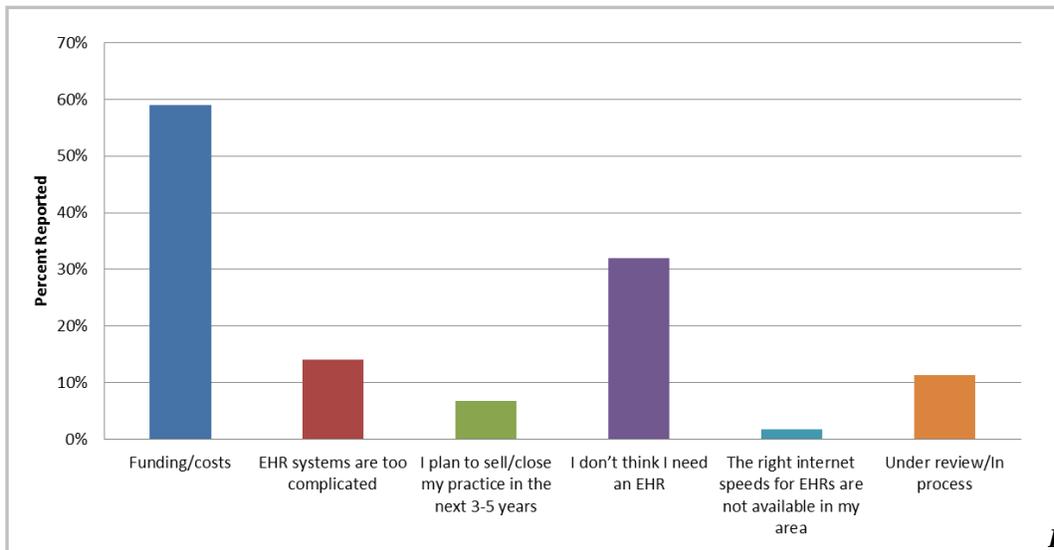


Figure 5 - EP

Reasons for EHR Adoption Resistance

Finally, lack of perceived need is the major reason healthcare organizations cited for not providing telemedicine services (53%), with funding costs second (19%), and reimbursement issues third (13%)

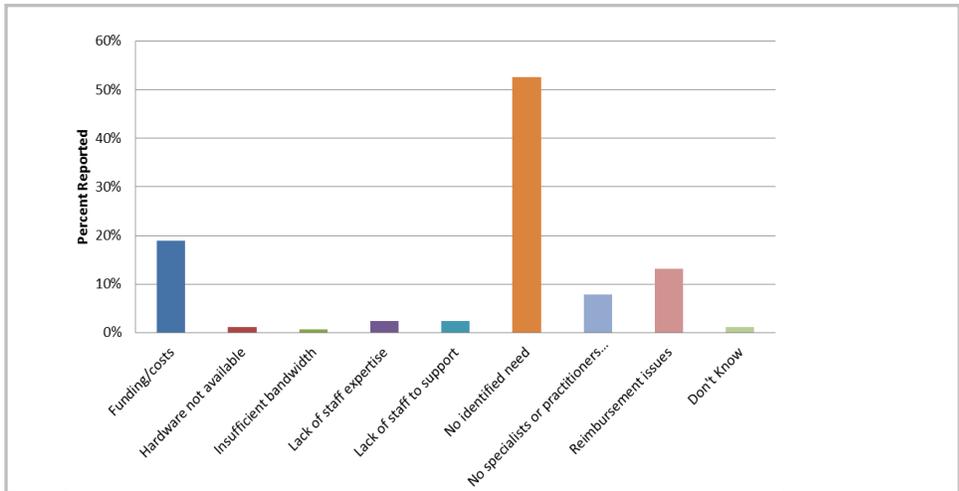


Figure 6 - Additional Reasons for EHR Adoption Resistance

The results of the survey will be used to more fully inform the education and outreach components of the MU Program. The survey also points out the challenges of attempting to get long term care and behavioral health facilities the resources and ability to implement EHRs and more fully use the technology that is needed to allow “aging in place” which is critical in an older, more rural state such as Maine.

The high participation rates of eligible providers and hospitals in the Maine MU Program in will likely be further enhanced through the proliferation of alternative payment models (APM’s) that necessitate certified electronic health information systems to facilitate care coordination and population care management. The results of the survey have been shared with the SIM grant governance body.

A2c. 2015 Current Statistics from Maine’s Electronic Health Records Incentive Program

In addition to information gathered through the ConnectMe Authority the state conducts data analysis of program information through the EHRIP’s state level repository system to identify program progress and quality to define outreach methods for providers. For more information on detailed outreach methods regarding the EHR Incentive Program please refer to Section B of the SMHP on page 64.¹⁴

¹⁴ Hyperlinked Crosswalk

A2c1. 2011- 2015 Maine Eligible Hospital Participation

2015 Eligible Hospital Participation					
Hospital Type	No. Participating	Payment Year 1	Payment Year 2	Payment Year 3	Total
Critical Access	16	\$ 5,562,103	\$ 3,642,183	\$ 825,635	\$ 10,029,921
Acute Care	20	\$ 18,409,791	\$ 14,419,368	\$ 3,673,568	\$ 36,502,727
Total Paid EHs	36				\$ 46,532,648

Table 3 - 2011-2015 Eligible Hospital Participation

2011-2015 Eligible Hospital Meaningful Use Completion			
Stage 1		Stage 2	
33	92%	9	25%

Table 4 - 2011-2015 Eligible Hospital Meaningful Use Completion

2011-2015 Eligible Hospital CEHRT Inpatient Vendors in Maine Hospitals	
Cerner	EPIC
Orion Health	MEDHOST, Inc.
MEDITECH	McKesson
CPSI (Computer Programs and Systems), Inc.	Allscripts

Table 5 - 2011-2015 Eligible Hospital CEHRT Inpatient Vendors in Maine Hospitals

A2c2. 2011-2015 Maine Eligible Provider Participation

Maine launched the Medicaid Meaningful Use Incentive Program in October 2011. The first program year all applications were for AIU. Attestation of meaningful use began in the second year of operation – 2012. By the end of 2014 program year 52% of providers attested to Stage 1 MU compared to 48% in 2012.

HIT MU Program Trend		
Program Year	AIU	MU
Program Year 2011	1285	0
Program Year 2012	682	627
Program Year 2013	330	1124
Program Year 2014	195	1197
Total by Program Year	2492	2948

Table 6 - HIT Meaningful Use Program Trend

AIU by Program Year and Eligible Provider Type					
Provider Type	Program Year 2011	Program Year 2012	Program Year 2013	Program Year 2014	Total
CNM	28	12	10	9	59
DENT	13	61	16	8	98
MD	949	446	168	99	1662
NP	283	160	131	76	650
PA	12	3	5	3	23
AIU-only	1,285	682	330	195	2,492

Table 7 - AIU by Program Year and Eligible Provider Type

Meaningful Use by Program Year and Eligible Provider Type					
Provider Type	Program Year 2011	Program Year 2012	Program Year 2013	Program Year 2014	Total
CNM	0	11	22	32	65
DENT	0	0	12	15	27
MD	0	477	847	869	2,193
NP	0	133	238	274	645
PA	0	6	5	7	18
MU-only	0	627	1,124	1,197	2,948

Table 8 - Meaningful Use by Program Year and Eligible Provider Type

AIU and MU Combined Eligible Provider Total				
Program Year 2011	Program Year 2012	Program Year 2013	Program Year 2014	Total
1,285	1,309	1,454	1,392	5,440

Table 9 - AIU and Meaningful Use Combined EP Total

Progression to Stage 1 has been steady. 44% to 54% of Physicians and midlevel providers (NP, CNM and PA's) have completed Stage 1. Progression to Stage 2 has been minimal through program year 2014. We expect to see this change in program year 2015 as all providers will move to Modified Stage 2.

Eligible Provider Progression AIU to Stage 1 and Stage 2 MU								
Provider Type	AIU	MU	Total All	Stage 1	% Stage 1	Stage 2	% Stage 1 to Stage 2	% of all to stage 2
CNM	59	65	124	62	50%	3	5%	2%
DENT	98	27	125	27	22%	0	0%	0%
MD	1,662	2,193	3855	2,084	54%	109	5%	3%
NP	650	645	1295	618	48%	27	4%	2%
PA	23	18	41	18	44%	0	0%	0%
Report total:	2,492	2,948	5440	2,809	52%	139	5%	3%

Table 10 - Eligible Provider Progression AIU to Stage 1 and Stage 2 MU

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Top twenty vendor use in Maine for each program year.

Eligible Provider CEHRT Vendor Use by Program Year				
Rank by % of use	2011	2012	2013	2014
1	GE Healthcare	GE Healthcare	GE Healthcare	GE Healthcare
2	Epic Systems Corporation	Epic Systems Corporation	Epic Systems Corporation	Cerner Corporation
3	Cerner Corporation	Allscripts	Allscripts	MERIDIOS_LTD
4	Allscripts	ECLINICALWORKS	ECLINICALWORKS	Epic Systems Corporation
5	NextGen Healthcare	LSS DATA SYSTEMS	athenaHealth	HEALTHPORT_LLC
6	SuccessEHS	Cerner Corporation	SuccessEHS	Allscripts
7	ECLINICALWORKS	SuccessEHS	CompuGroup	RHAPSODY
8	CompuGroup	Practice Fusion	NextGen Healthcare	athenaHealth
9	LSS Data Systems	CompuGroup	Vitera Healthcare Solutions	ECLINICALWORKS
10	McKesson	NextGen Healthcare	Askesis Development Group	ORION_HEALTH
11	Networking Technology dba RxNT	LSS Data Systems	McKesson	LSS Data Systems
12	Sage	Mitochon	LSS Data Systems	NextGen Healthcare
13	HealthPort	athenaHealth	Networking Technology dba RxNT	SuccessEHS
14	athenaHealth	Defran	Elekta IMPAC	Vitera Healthcare Solutions
15	Elekta IMPAC	e MDs	Greenway Medical Technologies	DENTRIX_ENTERPRISE
16	e MDs	Indian Health Service	Abraxas Medical Solutions	McKesson
17	AmazingCharts	Networking Technology dba RxNT	Practice Fusion	CompuGroup
18	Practice Fusion	Elekta IMPAC	Smoky Mountain Information Systems	Indian Health Service
19	GEMMS Inc	McKesson	Drfirst	Elekta IMPAC
20	Henry Schein Medical System	Anasazi Software Inc	Henry Schein Medical System	Kennebec Behavioral Health

Table 11 - Eligible Provider CEHRT Use by Program Year

A2c3. 2015 Maine FQHC/RHC Eligible Provider Stats

Maine has 39 FQHC/RHC practice sites in the state. 323 providers from those sites have participated in the Medicaid EHR Incentive Program since the inception of the program in 2011. 85% of those providers have completed Stage 1. We expect strong participation to Modified Stage 2 for our FQHC/RHC sites in 2015.

AIU only: 13 sites, 41 providers - 13%
 Stage 1: 23 sites, 275 providers – 85%
 Stage 2: 3 sites, 7 providers – 2%

A2c4. 2015 Maine Indian Health Service Eligible Provider Stats

The state of Maine currently has four Tribally Administered programs. The programs are administered by the Nashville Area of the Indian Health Service Federal Health Program for American Indians and Alaska Natives. In addition, there is one Federal Direct Care Service Facility. Current statistics from the EHRIP show that all four of these Tribally Administered Healthcare Services and the Federal Direct Care Service Facility have eligible providers that are participating in the EHRIP.

2015 IHS Eligible Provider Participation				
IHS Healthcare Service Facility	Total EHRIP Registered EPs	AIU EPs	Stage 1 MU EPs	Current CEHRT Vendor
Houlton Band of Maliseet Indians	1	1		Resource and Patient Management System (RPMS)
Passamaquoddy Tribe Indian Township	3	3	3	Resource and Patient Management System (RPMS)
Passamaquoddy Tribe Pleasant Point	8	8	3	Resource and Patient Management System (RPMS)
Penobscot Indian Nation	3	3		Resource and Patient Management System (RPMS)
Micmac Service Unit	1	1		Resource and Patient Management System (RPMS)

Table 12 - 2015 IHS Eligible Provider Participation

A2c5. 2015 Maine Non-Eligible Providers

Maine realizes the majority of behavioral health providers are ineligible for participation in the CMS Meaningful Use program, through the incorporation of program eligible primary care providers into the CMMI funded SIM BHHO structure these ineligible behavioral health providers will have access to and the ability to collect information coming from the Meaningful

Use Program for better care coordination and overall statewide HIT integration. As discussed in Section B in the EHR Incentives Integration to SIM Funded Health Homes, HRSA Funded FQHC facilities are also incorporated into the Health Home model for the same purpose. Please refer to page 54¹⁵ for further information on the Health Home movement.

Section A. Part 3. Privacy and Security

Respecting individuals' right to privacy and protecting their personal health information is critical to the successful widespread adoption and use of health information technology and exchange by health care providers.

In 2013, the Department's procurement protocols added an additional requirement to its contract checklist to include a check-off that a BAA or other use of data agreement is included as an addendum to the contract or that no PHI will be accessed or viewed. This requirement ensures that appropriate privacy and security laws are adhered to from the beginning of the contract process.

Currently, the protection of health information is handled through the DHHS Director of Healthcare Privacy who serves as our Department's Privacy Officer, and our offices have Privacy and Security Officials or Privacy Liaisons who work to follow state and federal healthcare privacy laws, including the Health Insurance Portability and Accountability Act of 1996, or HIPAA. The Department implements and updates confidentiality policies, procedures, training and forms that the law requires for us to keep health information protected, whether that information is part of a conversation, in a paper chart, or part of an electronic record. Only the minimum health information necessary to conduct business is to be used or shared. Additionally, we only enter into agreements with other organizations to help us with our business processes if they agree to safeguard the information as the law requires.

Maine DDHS will also investigate any possible breach of patient or client data that happens at a Department office or with one of our vendors or business associates. If an actual breach occurs, the Department will contact individuals whose information is at risk, and report the breach to government regulators.

In MaineCare Services, the Operations Division Director assumes the role of the HIPAA Security Officer. A MaineCare employee has been designated as the Privacy Officer. These individuals are key members of the Department's privacy and security group and oversee compliance, training, and resolution of HIPAA and other privacy incidents. As an example, MaineCare issues a weekly message from the Medicaid Director. Each week's message includes a HIPAA tip of the week. In addition, employees' annual evaluations include a component on the employee's performance with respect to privacy and security issues and compliance.

¹⁵ Hyperlinked cross-reference

Section A. Part 4. Inventory of Existing Technical Systems and Assets

A4a. Meaningful Use-specific HIT Technology Assets

As described in Maine's 2011 SMHP, Maine developed, tested and implemented an in-house technical solution for its Meaningful Use Program. This approach allowed Maine to develop a phased in implementation incorporating new requirements aligning with each stage of Meaningful Use.

Maine's MU Program began processing incentive payments through its new system in October 2011. The system implementation continues to be updated by the State's Office of Information Technology in response to evolving requirements from CMS and Maine's MU Program. To incorporate and accommodate changes to the MU Program; software releases are typically performed quarterly but may be rescheduled as needed. Changes follow established State practices for application development, security, accessibility and deployment. Typical changes include support for additional requirements for the MU Program as established by CMS, and/or enhancements to improve workflow.

The MU Program uses the following primary system components:

- Maine's Meaningful Use "HIT Database" – Maine's State Level Repository (SLR)
- Maine's Meaningful Use "Wizard" – for collecting data from providers.
- Maine's Meaningful Use "Front End" – for program administration
- Maine CDC's "Registration Wizard" – for CDC provider registration
- Maine CDC's "Registration Editor" – for CDC registry administration

The following sections provide a brief description of each system component identifying the high-level architectural design (i.e. implementation approach).

A4a1. Maine's Meaningful Use "HIT Database"

- **Overview:** At the core of Maine's internally developed system implementation supporting the MU Program is an Oracle relational database referred to as the "HIT Database." The database is used to manage processes and data related to the MU Program and it functions as Maine's State Level Repository (SLR). Data exchange interfaces have been setup to allow information to flow between Maine's SLR and CMS's National Level Repository (NLR). Maine's SLR has been designed to maintain flexibility while enforcing data-integrity. The HIT Database has numerous data constraints as well as dozens of supporting lookup tables which can be customized to support MU program changes. Maine has implemented multiple system components that interact with the HIT Database to enable the data to be maintained as well as for generating viewable and printable reports based upon information within the HIT Database.
- **Technical Summary:**
Maine's HIT Database consists of a single production Oracle database instance (hitprd) containing three separate but related datasets (or schemas). The primary dataset

(hit_admin) includes MU incentive payment related data, the second (CDCRegistration) includes CDC related registration data and the third (Reporting) is used strictly to support analytical reporting efforts based upon data in the other two schemas. In addition to using Oracle to implement Maine's SLR, Maine also uses a variety of technologies to process data exchanges between the SLR and the NLR as defined by CMS reporting requirements.

A4a2. Maine's Meaningful Use "Front End" (a.k.a. mEHRIP)

- **Overview:** The primary system component that HIT Specialists and auditors interact with is commonly referred to as the "Front End". This web enabled user interface is accessible through a web browser (e.g. Internet Explorer). The Front End interface provides a secure process for each step of the MU Program incentive payment process starting with the generation of the initial welcome email to an EP or EH, and continuing with eligibility determination and then MU submission, attestation and final payment. Each step of the process is documented and validated with built-in checks and verifications before moving to the next step. . As HIT specialists and auditors process incentive payments, the Front End displays informational prompts guiding users through the process. The Front End manages provider MU submissions by interacting with a separate application, the MU Wizard, which is described below.
- **Technical Summary:** The primary functionality accessible through the front-end application uses Oracle APEX. Data accessed by, or entered through the Font End, is maintained within Maine's SLR. The front-end application includes hundreds of web-pages containing logic that is updated as part of a managed software development lifecycle. The front end also has the capability to call viewable and printable reports that are generated through an external reporting tool (Cognos).

A4a3. Maine's Meaningful Use "Wizard"

- **Overview:** The Meaningful Use Wizard is a stand-alone application which collects and populates Meaningful Use data which is accessible and viewable through the Front End. The Wizard collects data on the MU measures for the appropriate program year and MU definition year (MUDY) from Eligible Professionals which is fed into Maine's SLR. Once the data is in the SLR, it is accessible in the Front End Application. The Wizard supports Medicaid MU eligible professionals similar to CMS's Medicare Meaningful Use portal. The Wizard prompts users to enter appropriate and validated Core, Menu and clinical quality measures (CQMs). The Wizard submits that information to the State's MU Program via secure FTP where it is loaded daily into the SLR for review and approval by HIT Specialists.
- **Technical Summary:** The Meaningful Use Wizard is a .NET 4.0 desktop application installed on a computer at an EP's practice. The Wizard displays the appropriate Meaningful Use measures to the user based on the eligibility information submitted for the EP. The current CEHRT and other factors are reviewed by the HIT Specialist who confirms the appropriate MUDY, Stage, Stage Iteration (1st, 2nd, ...) and reporting period

(90/356) to be submitted. Once the HIT Specialist completes the pre-requisite work required a server-based process then provisions the Meaningful Use Wizard and the provider NPI for the appropriate MU attestation submission.

- Note: Dually Eligible Hospitals (DEH) do not use the Wizard due to the submission of MU attestation measures via the Medicare MU portal which are then delivered to the SLR via the NLR C5 process.

A4a4. Maine CDC's "Registration Wizard"

- **Overview:** Providers download the CDC Registration Wizard from the state website. The CDC Registration Wizard is a stand-alone "one-stop shopping" application which enables health care providers to register with four Maine CDC Health Registries (Immunization, Syndromic Surveillance, Electronic Lab Report and Cancer). Demographic information is entered once and providers use a drop-down menu to check off the registries they want to register at. The Registration Wizard also collects information on whether a provider would be interested in participating in additional registries (Chronic Disease and Healthy Weight).
- **Technical Summary:** The CDC Registration Wizard is a .NET 4.0 desktop application installed on a computer within a provider's practice (similar to the MU Wizard).

A4a5. Maine CDC's "Registration Editor"

- **Overview:** The CDC Registration Editor is a stand-alone application developed to support Maine CDC users. It allows staff to view and edit registrations made by health care providers with the four CDC Health Registries (Immunization, Syndromic, Surveillance, Electronic Lab Report and Cancer) and to view interest expressed by providers about the proposed Health Weight and Chronic Disease registries.
- **Technical Summary:** The CDC Registration Editor is a .NET 4.0 desktop application, installed on the personal computers of selected Maine CDC Staff and Maine MU Program Staff.

A4b. Summary of Meaningful Use-specific HIT/HIE Technology Assets

- In consultation with CMS, Maine designed, developed, and implemented an in-house solution for attestation and payments for Medicaid-only eligible hospitals and eligible professionals.
- In October 2011, Maine’s current technical solution began to support the MU Program. It allowed MU Program HIT Specialists to process registrations that were submitted to the National Level Repository (NLR) and fed electronically to the State. The system enables the completion of the attestation and payment process for Year 1 Adopt, Implement, and Upgrade (AIU) payments.
- In April 2012, the State, in accord with its approved IAPD, performed enhancements to the system to allow payments over multiple years to be processed and tracked. Recognizing that some components of the registration and attestation have a distinct payment year level, the system distinguished Year 1 AIU attestations from Year 2 MU attestations.
- As of 2013, the system also includes the implementation of a desk-top application (MU Wizard) that EPs use to enter Meaningful Use (MU) data gathered from CEHRT reports which is sent electronically to the State. The addition of the Wizard system for the attestation for Meaningful Use Stage 1 successfully supported the attestation process for EPs for Meaningful Use while maintaining program integrity by requiring EPs to enter accurate and complete data before the system accepts the attestation and sends the data to the State. It also enables HIT specialists to review each Meaningful Use measure for accuracy and completeness, before the HIT specialist can continue the review and approval of the attestation and payment. Similarly, State auditors have the Wizard data available for both pre- and post-payment audits.
- Maine’s CDC Registration Wizard and Editor are now also supporting MU Activities within Maine CDC by enabling providers to register for Maine CDC Health Registries (Immunization, Syndromic Surveillance, Electronic Lab Report and Cancer).
- To meet MU definition year 2014 and Stage 2, as of 2014, the various HIT systems were updated to includes the ability for EPs to submit MU measures for definition year 2014 along with Stage 2 specifics including CQMs with specific domain requirements and the collection of exceptions.
- Maine will be implementing Stage 3 requirements as they are developed, defined and approved by CMS as Maine plans to continue updating its systems and processes to meet the goals and objectives of the HITECH Act.

Maine’s MU Program also uses components from MIHMS, discussed in greater detail in the next Section A.4b below:

MIHMS System Component	MU Program Utilization
MIHMS Financial Claims Payment Process	Data is accessible to MaineCare to identify and verify claims and data for the MU Program
MIHMS Provider Enrollment Portal	Used by the program to validate Medicaid provider status.
MIHMS Data Warehouse/Decision Support System	Data is accessible to MaineCare to identify and verify claims and data for the MU

Table 13 - MIHMS/Meaningful Use Components

A4c. Inventory of Major State HIT Technology Systems and Assets

Maine’s Office of Information Technology (OIT) is housed within the State’s Department of Administration and Financial Services (DAFS). OIT operates and maintains an application inventory of all State Systems depicting how each system aligns with each program. It also identifies data exchange interfaces between each system. The application inventory and diagram were critical resources used in the creation of Maine’s 2011 SMHP and as a reference source for this 2015 SMHP update.¹⁶

The following diagram developed for the 2011 SMHP provides a high level representation of the systems related to Medicaid management, administration, and oversight.

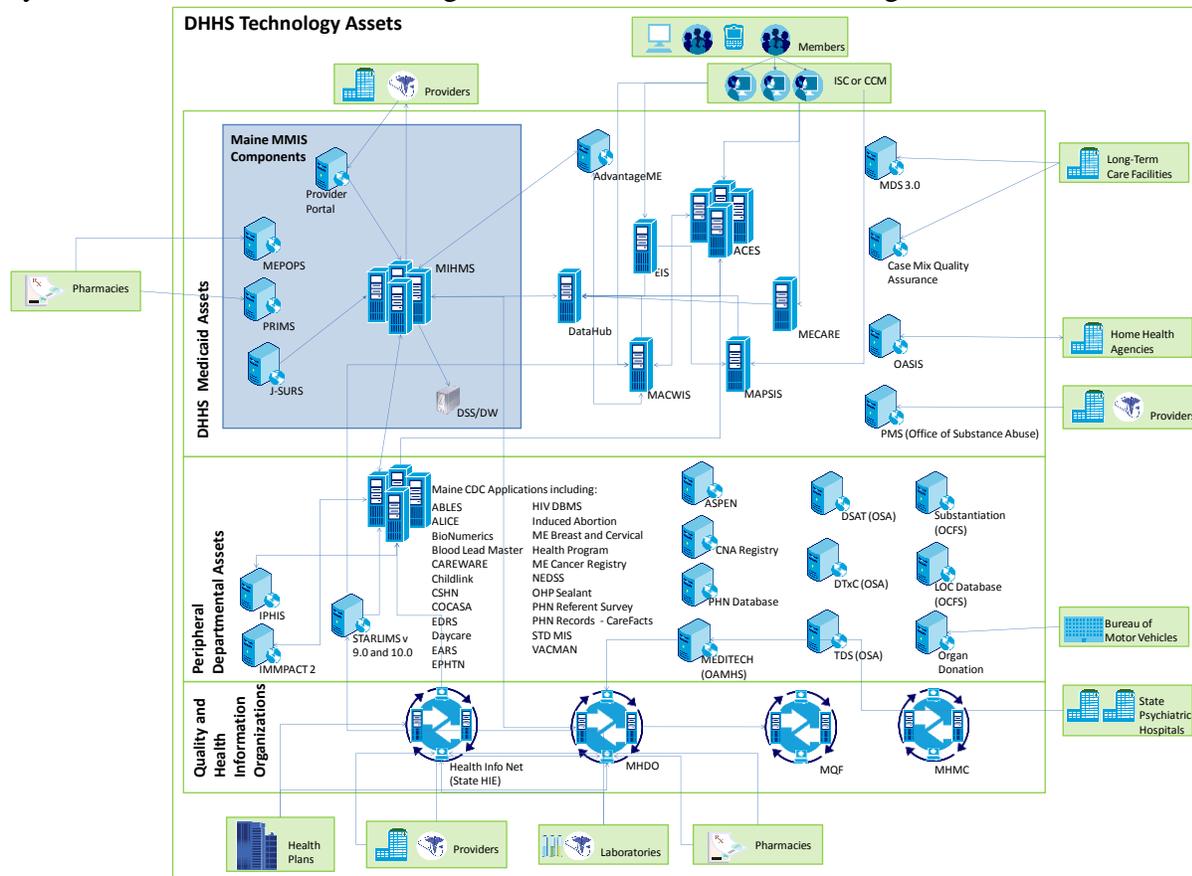


Figure 7 - DHHS Technology Assets and Schematic 2015

A4c1. Maine’s Medicaid Management Information System (MMIS)

¹⁶ The CMS Final Rule identified ten administration and oversight areas that technology assets may be used to meet CMS requirements: Verifying Eligibility; Program Registration; Tracking Attestations; Payment Process; Audit Process; Reporting Requirements; Tracking Expenditures; Appeals Process; Provider Questions; Provider Communications.

In 2011, when Maine was developing its MU Program, it had just implemented a new MMIS system, MIHMS. After careful consideration and consultation with CMS, the State determined that the most optimal solution for its MU Program would be to develop a Meaningful Use system that is similar to other existing state IT systems, and leveraged the integrated network across all DHHS systems. For example, State MU Program staff use MIHMS to confirm that professionals and hospitals are enrolled as Medicaid providers; to determine if the number of encounters for a specific provider or practice are in line with the encounter information provided; and other checks. The following is a description of the MMIS system for illustrative purposes: MIHMS is an enterprise application built on a Java Framework providing access to the Oracle database that supports the application. It is an integrated system that supports claims processing, provider enrollment, care management, program integrity, information management, and case management. It also provides the administrative and operation system support for Maine's health care programs including MaineCare, Maine Eye Care, Maine Rx Plus, Drugs for the Elderly, Children's Health Insurance Program (CHIP), Adult Mental Health, Adults with Cognitive and Physical Disabilities, Children's Health Services, Substance Abuse, and Elder Services. The diagram below depicts the functions within MIHMS. The box that lies outside of MIHMS is Pharmacy Benefit Management which includes the pharmacy point of sale system and pharmacy claims adjudication.

Maine's Medicaid Management Information System

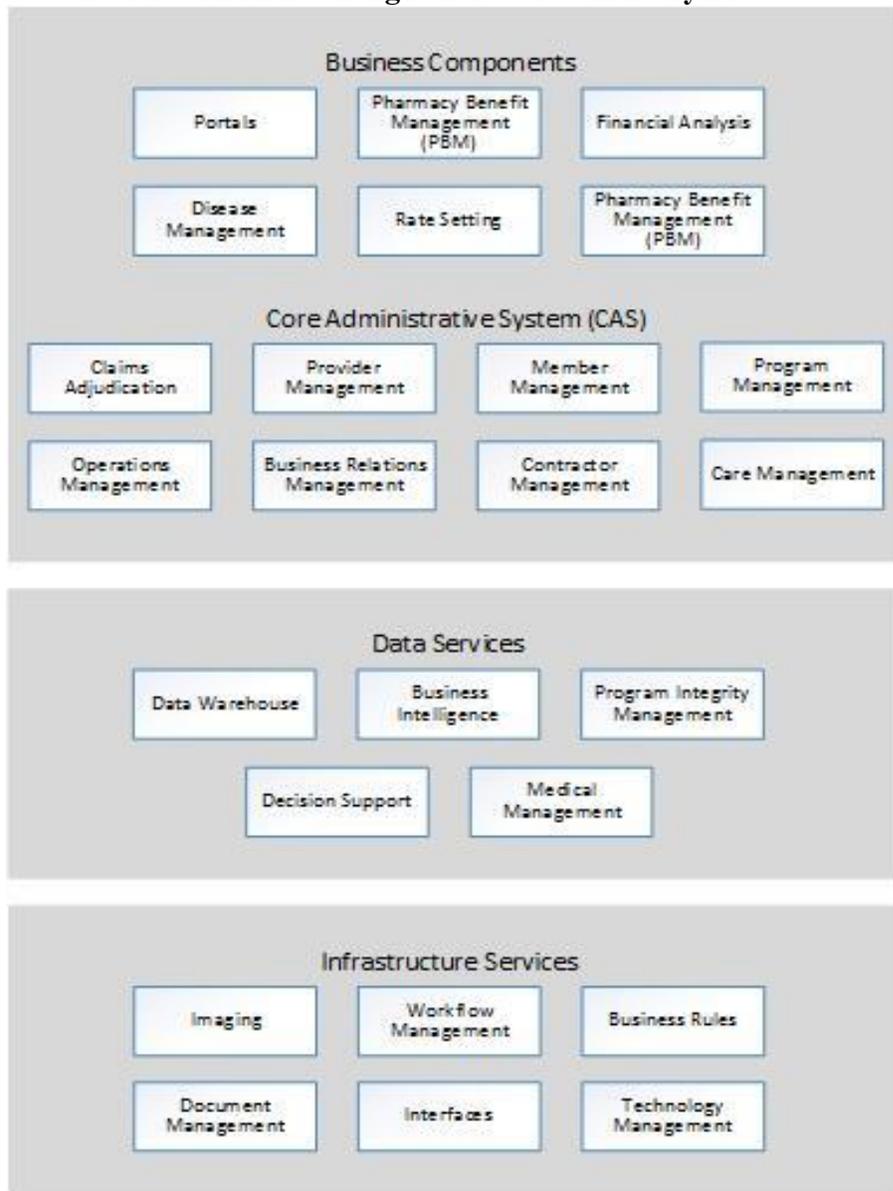


Figure 8 - Maine's Medicaid Management Information System

All of the MIHMS's applications are supported by the fiscal agent vendor's hardware and software. MIHMS has over 80 interfaces with other systems including Automated Client Eligibility System (ACES), Enterprise Information System (EIS), Maine Automated Child Welfare Information System (MACWIS), Maine Adult Protective Services Information System (MAPSIS), AdvantageME and others.

A4c1a. MIHMS Claims and Financial Management

The primary functions of MIHMS are claims adjudication; providing the data for reporting, analysis, and payment; and ensuring that all activities have the necessary levels of auditing and security to maintain the integrity of the process and system.

Claims submissions can be through the Provider Portal, the Electronic Data Interchange (EDI) Gateway for switch vendors, and elements of the Reports Manager combined with a subcontracted imaging solution using Good Health Systems (GHS) for paper claims. All claims are available in MIHMS including pharmacy claims. Claims status can be obtained via Contact Manager, Provider Portal, and MaineCare's Customer Service Representatives (CSR).

The financial claim payment process (Flexi) which occurs on a scheduled basis, examines and extracts the claims in MIHMS and transfers the financial information to the State's payment system, AdvantageME for payment.

A4c1b. MIHMS Provider Enrollment Portal

A key feature of MIHMS is the provider portal which allows providers to enroll and update information along with the Direct Data Entry (DDE) where providers submit individual claims, track the status of their submitted claims, and determine what claims are in "pay" status. If a claim contains an error, providers are able to correct it via the Provider Portal and resubmit it to MIHMS.

A4c1c. MIHMS Information Management – Data Warehouse/Decision Support System

The Decision Support System/Data Warehouse (DSS/DSW) collects and maintains data from MIHMS delivering advanced health care analytic capability with a Medicaid-specific data model and reports. The system meets Federal MIHMS certification and DHHS requirements and all MITA standards.

The application is built on an integrated, analytically ready database that feeds data to the Executive Information System (EIS) and Decision Support System (DSS). The EIS is a Web-based interface that provides fast access to hundreds of 'dashboard' indicators of program performance and disseminates quick, reliable summary-level information. It includes a comprehensive suite of built-in Medicaid reports with the ability to analyze data in a variety of ways.

The summary database matches to record-level detail in the DSS which has a Decision Analyst that provides flexible access to record-level detail in the data warehouse and customized report templates designed specifically for health care analytics. It provides Management and Administrative Reporting System (MARS) capabilities that support health care analysis and fraud and abuse detection and investigation. Each week the Decision Analyst function provides data from MIHMS to the user's workstation via Internet technology on:

- Medical claims data

- Drug data from the PBM
- Reference data
- Provider data
- Member data

A4c1d. Program Integrity–J-SURS

Maine’s Program Integrity unit, with the Division of Audit, is responsible for monitoring provider and Member compliance with applicable laws. The J-SURS system uses a *statistical analysis program on claims data that is fed from the MIHMS claims system to identify and remedy potential health care fraud, waste and abuse cases.*

A4c1e. MIHMS Contact Manager

The MIHMS Contact Manager system provides help desk and call tracking workflow allowing authorized users to access a wide variety of reports based on a number of statistical variables. The engine behind Contact Manager provides a tool to deliver Member eligibility and claim status information, deliver call center capabilities; member pre-qualification, eligibility and registration; prior approval; claim status; intelligent call routing, agent client (call tracking, workflow initiation); web chat; real-time contact metrics; and historical reporting.

The Automated Voice Response System (AVRS) queries MIHMS data via Web services showing any needed data, Member pre-qualification, prior approval, provider account payment status, claim status, third-party liability, drug coverage, and pricing.

A4c1f. MIHMS Interface with AdvantageME

AdvantageME is the State’s financial accounting system that interfaces with MIHMS to pay claims and track financial information. The application is built on a Java Framework and provides access to the Oracle database supporting the application.

A4c2. Maine Center for Disease Control (CDC)

Maine’s CDC is the state’s public health authority. Organizationally, it is an office within the Maine Department of Health and Human Services (DHHS).

A4c2a. PHINMS/Rhapsody/NEDSS – formerly part of the Integrated Public Health Information System (IPHIS)

Maine uses the Public Health Information Network Messaging Service (PHINMS) interoperability standards and the Orion Health Rhapsody Integration Engine to support its public health data exchanges including electronic laboratory reports, immunization records, and Maine's cancer registry.

Data is stored within the National Electronic Disease Surveillance System (NEDSS) and other CDC systems. Maine receives Electronic Laboratory Reports (ELR) from commercial labs and several hospital systems through Maine's Health Information Exchange (HealthInfoNet) and it receives ELRs directly from Maine's Health and Environmental Testing Lab (HETL) and four national reference laboratories. Maine also receives reportable diseases from all of Maine's hospitals and their associated urgent care centers, including symptoms reported in emergency rooms for syndromic surveillance. Data received is stored in the following two systems used for data analysis: the Early Aberration Reporting System (EARS) and BioSense 2.0. Cancer registry submissions may be made by either PHINMS or Secure File Transfer Protocol (SFTP) to the Central Cancer Registry (Elekta's Précis-Central system).

A4c2b. ImmPact – Maine's Immunization Information System

The Maine Immunization Program (MIP) within Maine CDC has a web-based Immunization Information System (ImmPact) that helps ensure effective public health strategies through the use of secure, accurate, and accessible information. The registry promotes client and vaccination management functions for a majority of pediatric providers and serves as a resource application for MaineCare. ImmPact tracks and reports provider vaccination administration and vaccine inventories; provides health tracking and quality assurance tools for clinician use; and access to current immunization trends, standards, and health information. ImmPact contains detailed immunization records for over half of the children in Maine. These records are electronic, portable, and patient-centric. Prior to 2010, MaineCare also used ImmPact to support the collection of information related to child Bright Futures preventive health visits. Between 2011 and 2014, Maine's CHIPRA funded Improving Health Outcomes for Children (IHOC) project worked in collaboration with the Maine Immunization Program to incorporate CHIPRA Immunization measures into ImmPact, which is the standard for today and the future. (See Section A4c6 page 40¹⁷).

The MU Program provides support for EPs and EHs to submit immunization data as required to meet Meaningful Use. The MU Program and Immunization staff work together to provide a seamless mechanism for EPs and EHs to report on immunizations and receive confirmation of their testing being accepted.

¹⁷ Hyperlinked Cross-reference

A4c3. Division of Licensing and Regulatory Services

The Department's Licensing and Regulatory Services Division maintains all human services licensing and certification activities for Maine. (The Licensing and Regulatory Services portal is used to confirm that an EH or EP is a licensed provider in Maine.)

A4c4. Financial Management Services

The Department's Financial Services Division is responsible for management, tracking and reporting of the MaineCare budget. (With direct oversight of MaineCare fiscal management systems, resources from Finance are key to the accurate tracking of EHR incentive payments, recouping payments if needed, CMS financial reporting requirements, and reconciling payments and MU Program administrative funds.)

A4c5. All-Payer Claims Database

Maine established the nation's first All-Payer Claims Database (APCD) via the Health Data Organization (MHDO), an independent State agency which implemented administrative data collection rules and regulations. The purpose of the Maine Health Data Organization (MHDO) as defined in Title 22, Chapter 1683, is to create and maintain a useful, objective, reliable, and comprehensive health information database that is used to improve the health care quality for Maine people and to promote transparency of the cost and quality of healthcare in the State in conjunction with the Maine Quality Forum through a publically accessible website.

The APCD currently collects four types of administrative data: individual eligibility data and paid dental, medical, and pharmacy claims. Across all file types, encrypted and protected health information links patient specific information together. Claims from commercial sources and Medicaid are added to the APCD on a quarterly basis and generally include claims paid through the end of the quarter before the most recently ended quarter; so, for instance, claims paid through Q2 2015 were added to the APCD in Q4 2015. Claims from Medicare are added with a longer lag, for example claims paid through Q4 2014 will be added to the APCD in Q4 2015. Note that the APCD does not include information about uninsured individuals or from payers with less than \$2,000,000 in annual premium and or premium equivalents.¹⁸

The advantage of Maine's APCD is the mandate that requires health insurance companies and third party administrators to submit claims data to the MHDO in a standardized format and frequency as prescribed in MHDO Rule Chapter 243. Please refer to the information listed in Section E on page 233¹⁹ for further information regarding the APCD activities.

A4c6. Improving Health Outcomes for Children (IHOC)

Maine and Vermont were among 10 state teams that were awarded demonstration grants (for the period of February 2010 through February 2015) to enhance the quality of care delivered to

¹⁸ It is important to note that the All-Payer Claims Database excludes the uninsured.

¹⁹ Hyperlinked Cross-reference

children in their states and inform best practices for the nation. IHOC has been funded by a grant from The Centers for Medicare and Medicaid Services (CMS) through Section 401(d) of the Child Health Insurance Program Reauthorization Act (CHIPRA). In Maine, MaineCare includes both Medicaid and the Children's Health Insurance Program (CHIP). The grant allowed the states of Maine and Vermont to test, develop, and expand the use of evidence-based child performance measures to include child behavioral health measures. The Maine IHOC initiative initially focused its initial health care delivery system improvement efforts on four pediatric practices involved in Maine's PCMH Pilot. MaineCare has continued to support the focus of IHOC through inclusion in the MaineCare operations plan funded by state and federal cost sharing.

In addition, the states expanded their information technology systems to improve the exchange of child health data and expedite service provisions to children in foster care. They tested and evaluated a pediatric medical home model for other states, particularly non-demonstration states, to expand child health improvement efforts. In addition to the core set, Maine examined the feasibility of other data collection and measure reporting. Maine conducted an environmental scan of all child behavioral health outcome measures being used by mental health providers and explored the feasibility of testing and integrating these measures into broader pediatric practice level reports.

A key element of the planning was to ensure that Federal and State resources were fully maximized and complementary, not duplicative or redundant. The Meaningful Use program was a targeted consideration in all these efforts. An example of the complementary use of funds to accomplish those goals would be the utilization of the Medicaid ARRA Section 4201 provider incentive payment program to help pay for the cost of adoption, implementation or upgrades of EHR systems in pediatric practices; ONC HIE funding to pay for interfaces to ensure connectivity to the state HIE network; and CHIPRA grant funding to develop data repositories for the collection, design, implementation, and evaluation of the automation of *Bright Futures*, as well as foster care health data system. For more details concerning IHOC please visit <http://www.maine.gov/dhhs/oms/provider/ihoc.shtml>.

The IHOC grant ended in February 2015. However, the State plans to continue the work done under the grant via regular federal and State funding under the State's Medicaid program. IHOC continues to focus on meaningful use of health information technology, including use of registries, coordinated patient data using the HIE, and development of quality improvement processes that rely on availability of clinical data from certified EHR systems.

A4c7. Pharmacy Benefit Management

The Pharmacy Benefit Management (PBM) program is a pharmacy benefit program for MaineCare members which includes:

- Interfaces with POS system and reporting applications
- Real-time access to both beneficiary and provider eligibility
- Online real-time summary information including number and type of providers, beneficiaries, and services
- Availability 24 hours a day, 7 days a week, 365 days a year

- Prior Authorization compliance with Federal and State regulations
- E-prescribing solution that works with Prior Authorizations and Point Of Sale (POS)
- Fully automated PRO-DUR system that meets Federal DUR regulations
- Fully functional RETRO-DUR system that meets Federal DUR regulations
- Medication Therapy Management Program
- Transmittal of adjudicated claims to the Data Hub for the MMIS system
- Pharmacy help desk availability to providers for clinical and technical support

A4d. Maine's Health Information Exchange

When the Office of the State Coordinator executed a four-year cooperative agreement with the Office of the National Coordinator, a significant portion of the agreement was dedicated to a contract with HealthInfoNet who was also named at that time, to be the Statewide HIE.

HealthInfoNet is an independent, nonprofit organization using information technology to improve patient care quality and safety.²⁰ The organization's core service line is the management of Maine's statewide health information exchange (HIE), a secure computer system for doctors, hospitals and other providers to share important health information and improve patient care. The HIE system links medical information from separate health care sites across the State to create a single electronic patient health record. This record is made accessible to authorized providers to support patient care.

The HIE continued its role after the close of the cooperative agreement and now contains records for close to all Maine residents and is connected to the vast majority of health care facilities in Maine. These facilities include hospitals, physician practices, federally qualified health centers, long-term care facilities, home health agencies, behavioral health providers, and independent laboratories.

Data categories managed by the HIE include: patient demographics, insurer, Accountable Care membership, primary care provider, visit/encounter history, laboratory and microbiology results, radiology reports, adverse reactions/allergies, prescriptions, diagnosis/conditions/problems (primary and secondary), immunizations, vital signs, and dictated/transcribed documents like hospital discharge summaries and provider visit notes.

HealthInfoNet provides a number of value added services to support providers in their adoption and use of health information technology as well as tools to support new and emerging models of care and care management. These include assisting providers with meaningful use attestation, single sign on to the state prescription monitoring program, public health reporting, and analytics services. HealthInfoNet also provides tools to support the needs of Accountable Care Organizations such as event notifications and predictive modeling tools.

²⁰ HealthInfoNet was incorporated in 2006 and is governed by a voluntary community-based board of directors and several board advisory committees run by Maine people serving on behalf of medical providers, public health, patients, government and business. The organization provides services across the State of Maine, and maintains its corporate office in Portland. One of the board members is the Director of the Maine DHHS Quality Improvement Office.

HealthInfoNet is the recipient of a number of federal grants that have helped to expand its services and extend HIE access to small, rural and specialty care providers across Maine.

- HealthInfoNet was the recipient of the [HIE Cooperative Agreement Program Grant](#), awarded in March 2010 by the Office of the National Coordinator for Health Information Technology (ONC) to 56 states, eligible territories, and qualified State Designated Entities (SDE) received awards.
- In 2011, HealthInfoNet was the recipient of an ONC grant designating it as one of the many [Regional Extension Centers](#) (REC) created across the country to provide education and technical assistance to help health care providers select, implement, and achieve meaningful use of certified EHR technology.
- In 2012, The State of Maine and HealthInfoNet were selected as one of five states to contract with the Center for Integrated Health Solutions (CIHS), funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Health Resources Services Administration (HRSA), to support electronic sharing of health records among behavioral health providers and general medical providers in Maine.
- In 2013, HealthInfoNet was one of three partners selected to help the State improve care and reduce health costs in Maine under the State Innovation Model (SIM) grant. One specific area of focus has been to integrate all MaineCare prescription claims information as discrete data within the medication history section of the HIE. MaineCare prescription history is now fully integrated within Maine's HIE. These activities are discussed in further detail in Section E.
- Also in 2013, HealthInfoNet was awarded a three-year grant to improve care coordination for Maine's veterans. Awarded by the Health Research and Services Administration (HRSA), the funding will be used to connect the VA Maine Healthcare System comprised of the medical center located in Augusta and 11 outpatient clinics to the health information exchange. (See Section A4e (2) for more detail.)
- As of 2015, HealthInfoNet has successfully become the first HIE in the nation to provide "viewing access" to Veterans Affairs (VA) clinicians. With the support of federal and state grant funding, HealthInfoNet (HIN) staff continue to work closely with VA Maine leadership to connect the VA health record systems to Maine's HIE. With view access, authorized VA clinicians are able to obtain important medical information from non-VA facilities to support clinical decision making and care coordination. All of Maine's VA facilities, including eight Community Based Outreach Clinics, three outreach centers, and the Togus Medical Center will be given access to the HIE Clinical Portal in 2015.

A4d1. Geographic Reach of HIN

The geographic reach of the HIE exchange is Maine--there is currently no exchange of HIT across state borders except for the Veterans Administration, where any VA facility nationwide can query information. However, MaineCare Members living in border towns do obtain services from providers in New Hampshire. HIN leadership has been in recent discussions with executive leadership from multiple NH hospitals and is likely to begin connecting some NH organizations in 2016. Conversations have also begun between HIN and Maine's largest health system MaineHealth about opportunities for including hospital data from New Hampshire hospitals that have been recently acquired by MaineHealth.

HealthInfoNet currently holds HIE data for:

- 35 Hospitals and over 450 ambulatory, behavioral health, and long-term care facilities
- Total Patients Included 1,480,952
- Maine Residents 1,266,777
- 97% of Maine Residents
- 1.13% of Maine Residents have Opted-Opt of the HIE

A4d2. Electronic Clinical Laboratory Ordering and Results Delivery

HealthInfoNet (HIN) supports Eligible Hospitals (EH) and Critical Access Hospitals (CAH) to meet Stage 2 Meaningful Use Core Measure 14, Electronic Reportable Laboratory Results. HIN works in close conjunction with Maine's public health authority, Maine Center for Disease Control and Prevention (Maine CDC) to establish and maintain real-time HL7 interfaces to deliver notifiable laboratory conditions using the Maine CDC prescribed PHIN Messaging System. HIN's HIE laboratory data is coded to the Logical Observation Identifiers Names and Codes (LOINC) standards. Laboratory results are also being standardized using SNOWMED codes where applicable. Using the LOINC and SNOWMED standards to exchange lab data is allowing for semantic interoperability across Maine.

A4d3. Electronic Public Health Reporting

HealthInfoNet has a long standing relationship with Maine CDC. HIN and Maine CDC collaborate to support the health care community by automating laboratory result exchange processes for 45 of the 72 diseases mandated for public reporting by the State of Maine. HIN uses the PHINMS transport standard required to communicate automated laboratory test results to the public health information infrastructure. HIN also provides the Maine CDC with public health syndromic surveillance information by leveraging ADT data messages from Emergency Room events of care. As of 2015 a contract has been signed with Maine CDC to help provider practices connect to HIN and report patient data. This supports a Maine CDC grant that is focused on better management of patients with type 2 diabetes and hypertension.

A4d4. Prescription Fill Status / Medication Fill History

HIN has two sources for medication data. HIN's medication information comes from adjudicated claims files from Surescripts and MaineCare. MaineCare provides prescription medication profiles for its 291,000+ members. Surescripts provides data from claims and electronically prescribed prescription medication profiles for patients as well as fill history from some pharmacies. The combination of these two sources of prescription medication information enables access through the statewide exchange to medication history profiles for approximately 70 percent of Maine's residents.

HealthInfoNet maintains an opt-out consent process for general medical information and an opt-in patient consent for certain behavioral health and HIV related information as required by Maine State law. The HIE has just over a 1% opt-out rate.

The statewide HIE, HIN, is not a covered entity, however it is considered a HIPAA business associate of all healthcare entities it conducts business with. If HIN performs functions or activities on behalf of DHHS within a business associate agreement, HIN is required to have security and privacy controls in place to safeguard and appropriately protect the privacy of protected health information. Utilizing HIN to manage the auditing, tracking, and aggregation of data could be beneficial for DHHS.

A4d5. Privacy and Security in the HIE

EHR technology is a powerful tool for improving the quality and coordination of care, and to improve health care outcomes. Sharing and exchanging personal health information must comply with HIPAA and applicable federal and State law.

Sharing protected health information (PHI) through EHR technology empowers both health care providers and patients to better manage health. It is essential that health care providers have access to the health information needed to care for patients where and when it is needed, while at the same time protecting patients' information. Achieving the right balance of access and privacy is the key to security in the current health care environment.

In 2013, under the auspices of the Office for the State Coordinator of Health Information Technology, a Legal Work Group was formed and conducted an exhaustive inventory and research of federal and State privacy and security laws and rules. The work products of this group have been used to inform state policy for appropriate access to PHI under the emerging HIT initiatives. In that same year, Maine enacted a statute establishing opt-in and opt-out procedures for Maine's statewide Health Information Exchange to allow mental health and HIV data to be exchanged through the state designated health information exchange.²¹

The law requires providers to display information in their offices on the benefits of having health care data in the HIE and easily accessible methods to opt-out of the HIE for general health data. The law also stipulates that patients must provide affirmative opt-in for mental health data to be included in the HIE. Maine's HIV laws also require affirmative opt-in to the HIE for HIV data. Substance abuse data is currently not submitted nor stored in the HIE. 42 CFR, part 2 presents a major obstacle to the goals and objectives of using electronic health information to manage care of people with drug and alcohol diagnoses.

A4e. Other Networks and Systems in Maine Employing HIT

A4e1. Federally Qualified Health Center Networks

Maine's 27 Federally Qualified Health Centers (FQHCs) provide services across the State to a significant portion of Maine citizens. A three-year grant awarded to the Maine Primary Care Association (MPCA), a Health Center Controlled Network allowed the MPCA to:

- Develop an immunization interface between the EHRs and the state immunization registry, IMMPACT2

²¹ For more information on the LWG please visit <http://www.maine.gov/hit/lwg/documents/LWGbackground.doc>

- Plan HIE architecture and business model, to include exchanging data from 19 MPCA members (representing multiple vendor platforms) in the HIN systems;
- Develop reports for the management of chronic conditions and preventive practices; framework for improving rates of reporting of Pay for Performance; and development of e-prescribing capabilities;
- Develop decision support tools to assist in identifying patients who may be eligible for federal or State assistance programs; and
- Be a focal point for the OMS Meaningful Use Program for education, outreach, and registration/attestation for EPs.

A4e2. Veterans Administration EHR Capabilities

The Veterans Administration (VA) has been using an EHR in VA clinical facilities since 1985. The VA uses an enterprise-wide information system called VistA, the Veterans Health Information Systems and Technology Architecture, as their EHR system which is installed and in use in all VA facilities in the United States.

VistA is a complete EHR that supports both Medical practices (including eligible providers) and inpatient care. VistA includes several common EHR capabilities including computerized physician order entry (CPOE), bar code medication administration, e-prescribing, and clinical guidelines. The VA uses VistA as the primary source of health information for veterans; no paper records are used in VA clinical facilities. The EHR data in VistA is stored at a regional level; all regional databases are connected nationally to allow any VA clinical facility to access any veteran's EHR. VistA is not a commercial product and is available as open source software directly from the VA website.

Maine has fifteen VA clinical facilities which includes one VA hospital and fourteen outpatient clinics and veterans centers throughout the State, of which only nine clinics provide direct patient care. As of 2014, Maine's VA Health System is a contracted participant with Maine's Health Information Exchange (HIE), HealthInfoNet (HIN). Via HIN's participation in the national eHealth Exchange network operated by Healtheway, bidirectional data exchange between the VA's national platform known as "VLER" and HIN is made possible. The VA also has begun to implement their ability to authorize staff access to HIN's HIE Clinical Portal to view medical information for Veterans who receive care in the private health care sector. With this "view" access, authorized VA clinicians are able to obtain important medical information from non-VA facilities to support clinical decision making and care coordination. All of Maine's VA facilities, including eight Community Based Outreach Clinics, three outreach centers, and the Togus Medical Center will be given access to the HIE Clinical Portal in 2015.

A4e3. Department of Corrections EHR Capabilities

The Department of Corrections (DOC) is currently pursuing the acquisition of an EHR system to manage the health information of individuals in the State's correctional institutions. Correctional Medical Services manages the care provided to inmates in correctional facilities and they currently do not have an EHR system. The Corrections Information System (CORIS) manages all information on adults and juveniles in correctional institutions or the community, but does not

contain any health information. MaineCare will have to coordinate with the Department of Corrections once they adopt and implement EHR technology to understand how offender health information can be shared in a statewide HIE to allow for individuals to access their records prior to entering the corrections system and after being released from the corrections system.

A4e4. Indian Health Center EHR Capabilities

Maine has five Indian Health Services clinical facilities all of which use the Indian Health Services – Resource and Patient Management System. All facilities are using a wide variety of capabilities within their EHR including CPOE, clinical guidelines, chronic care plans, condition specific reminders, active medication lists, and active allergy lists.

The Penobscot Nation Health Department’s EHR is exchanging information with providers outside the system, hospitals in the system, the State immunization registry, and the Maine CDC. All of the Indian Health Center clinical facilities in Maine have an electronic practice management (EPM) system implemented.

Currently there are sixteen EPs from the Indian Health Centers participating in the OMS Meaningful Use Program with six of these provider having met Stage 1. The MU Program regularly communicates with the tribes to provide education and outreach for this population.

A4e5. Broadband Technology Opportunity Program (ConnectME Authority)

In recognition of the critical importance of modern technology for education, health care, and business success in Maine, the Legislature created the ConnectME Authority (Authority) in 2006 as an independent State agency, to develop and implement a broadband strategy for Maine. The goal of the Authority is to facilitate universal availability of high-speed internet service (broadband) by providing a “pipe” where there is no pipe or in some cases, a bigger “pipe” which provides higher-speed broadband, and to increase the “take rate” (adoption) to greater than the national average. Increasing broadband access and take rates is critical to Maine’s economy, tele-health, distance learning and education.

The Authority increases access and take rates through its efforts to identify areas that do not have broadband access; selecting projects for broadband expansion; funding and administering the projects; providing oversight and assistance for the projects; and adhere to the Authority’s commitment to avoid duplication and encourage cooperative efforts. From 2007 through 2014, the Authority has awarded 122 grants totaling nearly \$10 million through a process that solicits, scores, and awards bids from public-private partnerships.

The success of the ConnectME initiatives is done with much collaboration with other Maine State agencies, federal partners, municipalities, and public and private stakeholders. For example, the Department of Economic and Community Development held ten educational forums for small business owners on the benefits of broadband; the Department of Education led the Technical Assistance project; the State’s Health Information Technology (HIT) efforts with several State agencies provide federal funding for hospitals and health care providers to use electronic health records to improve health quality and outcomes and efficiencies; University of Maine communications and network services project have improved broadband education opportunities; the federal Agricultural Act of 2014 provides loans and loan

guarantee programs for improvement or acquisitions of internet facilities for rural communities; and the FirstNet funding opportunity which was recently awarded \$1 million three-year federal grant for a dedicated Maine public safety broadband network as part of the National Public Safety Broadband Network.

Over the past four years, the ConnectME Authority has completed:

- An inter-active on-line Mapping and Inventory project which among other results, now enables citizens and businesses to enter a street address which instantaneously tells them whether internet service is available; the speed of internet services; and which vendors serve that area;
- A Planning Project benchmarking the benefits and the drivers of internet with a particular focus on the use of tele-health to improve quality and health outcomes and cost efficiency;
- A Capacity Building Project to increase the benefits and use of broadband by businesses, residents and local support organizations which resulted in a detailed and thorough report and recommendations; and
- Technical Assistance Project, which was an adult education effort for Maine citizens conducted through community presentations, workshops and coursework making 21st century skills available to all.

Under a cooperative agreement with the Meaningful Use Program, the ConnectME Authority conducted a healthcare provider survey which included questions about EHR use and access to broadband internet access for tele-health and other purposes.

A4e6. Tele-Health

Tele-health refers to the use of electronic communication by a health care provider to deliver clinical services at a distance for the purpose of diagnosis, disease monitoring, or treatment, either by telephone or combined video/audio. Tele-health can be particularly useful in a rural state like Maine where some health care services are distantly located from the community and where workforce challenges frequently limit access to many services, including, but not limited to, specialty services. This is especially true with time sensitive diagnoses – for example acute stroke – in which treatment windows are very short, and specialty providers are critical to the chain of survival and recovery. It is also acutely true for services such as child psychiatry, where there are only a few health care professionals providing in these specialized services.

Tele-home-health services allows citizens to remain home and receive enhanced self-care, medication management, and chronic disease management, therefore improving health and reducing re-hospitalization rates. These services not only benefit home based citizens, but also result in higher quality, better outcomes, and reduced costs of transportation and higher cost services.

In some ways, the MaineCare program is more flexible than Medicare with respect to telemedicine. There are no specifications about eligible locations or facilities for the originating site, and all providers already approved to deliver MaineCare reimbursement for services and eligible to do so by telemedicine. However, the quality assurance responsibilities of the

MaineCare administration leads them to mandate a detailed justification for service delivery by telemedicine, formal informed consent procedures, and a documented plan for assessment of patient satisfaction and outcomes.

MaineCare is in the process of updating its tele-health rules to allow additional services to be performed using this flexible, cost-effective, and high quality method. The Department expects to publish the proposed rule in early summer 2015.

For more information on Maine's telemedicine policies and activities please see the [Maine Telemedicine Reimbursement Guide](#).

A4f. Federal Law: HIPAA2: 5010 / ICD-10

The International Classification of Diseases (ICD) is the international standard diagnostic classification for general epidemiological, health management, and clinical use. As part of HIPAA Administrative Simplification, the United States HHS mandated that all health care entities upgrade diagnosis (ICD-9-CM) and inpatient procedure codes (ICD-9-PCS) to ICD-10-CM and ICD-10-PCS, respectively. The ICD-10 code set is a full replacement of the ICD-9 code set that will provide additional granularity for diagnosis and procedure codes.

The anticipated benefits for Medicaid plans include more efficient operations, more accurate claim payments, better disease management, and improved fraud and abuse detection. If changes are properly implemented, that may mean lower program costs and better service and care for Medicaid beneficiaries. Although the compliance dates are three years away, the magnitude of these changes requires that MaineCare begin assessing the impact of the changes on their technology, business processes, and staff. Action is needed now to allow adequate time for developing project plans and budgets and designing, testing, and implementing the necessary changes.

MaineCare continues to plan implementation of ICD-10 in accordance with CMS requirements, has currently implemented the transition from ICD-9 to ICD-10 on October 1, 2015.

A4g. Medicaid Information Technology Architecture (MITA)

Maine's Meaningful Use Program is based in part on CMS's Medicaid Information Technology Architecture (MITA) and Maine's MITA State Self-Assessment (SS-A). MITA provides states with a framework to plan technology investments to design, develop, enhance and install Medicaid Management Information Systems (MMIS). The MITA SS-A provides a model to assess a state's current capabilities for measuring progress toward its desired future state. MITA fosters the integration of business and Information Technology transformation to improve the administration of Medicaid programs.

The objectives of Maine's MU Program are aligned with MITA in that both focus on developing reusable services that can be shared across multiple programs. Both aim to improve the quality of

care by supporting the integration of disparate information systems for interoperability, integration, open architecture, and coordination with partners to integrate health outcomes.²²

A4g1. MITA State Self-Assessment (SS-A)

Maine's 2011 SMHP "As-Is" assessment was conducted in 2010.²³ At that time, MaineCare was replacing its prior MMIS, called MeCMS, with a new MMIS, the Maine Integrated Health Management Solution (MIHMS). The SS-A focused on the anticipated MIHMS implementation and the corresponding MaineCare business processes.

The SS-A resulted in the following:

- A benchmark for MaineCare to assess additional functionality needed to meet outstanding Federal and State initiatives; and
- A process to identify critical functional gaps efficiently based on what the current environment can or cannot support.

A4g2. Maine's High-level Findings--Business Assessment

Maine's MITA SS-A determined that Maine's business processes were already aligned with MITA through the system design and development phase.²⁴ MaineCare's SS-A resulted in defining the organization's business needs using State-specific requirements, industry best practices, and MITA-defined capabilities. Many of the individual business process were determined to be functioning at a capability level of three (3) which was the highest level that could be attained at the time.

The information in the MITA SS-A helped inform the requirements and design of the MU Program including the following business areas:

- Business Relationship Management
- Operations Management
- Program Management
- Program Integrity Management
- Provider Management

A4g3. Maine's High-level Findings – Technical Assessment

²² See appendix A-4 for a table that displays the alignment of MITA vision, goals, and objectives with the vision, goals, and objectives of Maine's M U Program.

²³ The information Section A4g is based upon Maine's MITA Self-Assessment (SS-A) which was completed in 2010 and which had been incorporated into Maine 2011 SMHP. It is retained in this 2015 version of the SMHP as many parts of the SS-A are still relevant to Maine's MU Program.

²⁴ See Appendix A-5 for a table summarizing the MITA Business Assessment including the MITA Business Area, the capability maturity model level, and high level findings.

Maine’s MITA SS-A included interviews with MaineCare Technical Subject Matter Experts (SME) who provided an understanding of the technical capabilities of MIHMS and helped to build the following Technical Capabilities Matrix:

MITA Technical Area	High-level findings
Business-enabling services/Decision Support	<p>A workflow process is included in the MIHMS solution</p> <p>Claims Management is an example of the successful incorporation of BRM</p> <p>There is no Foreign Language support</p> <p>A Decision Support System / Data Warehouse (DSS/DW) is used</p> <p>Ad-Hoc reporting capability exists</p> <p>Data Mining was not used in MIHMS at the time of the SS-A. It is currently being used.</p> <p>Manual statistical analysis was performed by the Muskie Institute at the time of the SS-A. Currently, both Muskie Institute and DHHS perform statistical analyses.</p> <p>There are no Neural Network Tools employed in MIHMS</p>
Access channels	<p>Providers and Members have access to information via the web portals</p> <p>Browser and Integrate Voice Responder (IVR) are access points to the system</p>
Interoperability channels	<p>MIHMS does not use Service Oriented Architecture (SOA); no service structuring and/or invocation of services in MIHMS</p> <p>An Enterprise Service Bus approach is not being employed in the MIHMS</p> <p>No orchestration and/or composition is being used in the MIHMS</p> <p>Data exchanged with external interfaces uses MITA standards and formats</p>
Data management and data sharing	<p>The capability exists to monitor all incoming information from all interfaces</p> <p>While there are no Electronic Health Records inputs to MIHMS, the State’s MU Program creates the vehicle for EP and EH Meaningful Use reports to be shared with the State</p>
Performance measurement	<p>Performance measures are primarily systems focused</p> <p>At the time of the SS-A, the capability existed to generate performance dashboards; currently dashboards are generated.</p>
Security and Privacy	<p>At the time of the SS-A, Public Key Infrastructure, authentication devices, and access restriction going down to the data element level functions were not in use. Currently they are in use through the system.</p>

MITA Technical Area	High-level findings
Adaptability and extensibility	<p>MIHMS uses rules engine functionality</p> <p>Coding changes may be necessary if changes are being made to the base system</p> <p>MIHMS supports XML and a number of other platforms</p>

Summary of MITA Findings

- The objectives of Maine’s MU Program are aligned with MITA in that both focus on developing reusable services that can be shared across multiple programs.
- Both aim to improve the quality of care by supporting the integration of disparate information systems for interoperability, integration, open architecture, and coordination with partners.
- Both strive to improve the quality and efficiency of health care delivery and population health.
- Results of the MITA SS-A provided information about the business processes and technical assets to be used to manage, administer, and oversee Maine’s MU Program.

A4g4. MITA 3.0 SS-A Intent

It is the intent of MaineCare to conduct a MITA 3.0 State Self-Assessment (SS-A) within the 2016 calendar year to enhance, further, and align the state's programmatic efforts to aid in the Medicaid systems integration. Since Maine's 2010 MITA 2.01 SS-A there have been several federal updates to the regulations that govern the Medicaid Program. MaineCare would like to align both the current and future systems implementation and development for adherence to the MITA Seven Conditions and Standards (7C&S) to ensure that development efforts achieve the highest maturity and capability levels possible. The ultimate product of this SS-A will define Maine's "To-be" state and develop a new roadmap for the 5-10 year plan for input into future versions of the SMHP and IAPD submissions to CMS for enhanced federal funding. Until this effort is completed MaineCare will focus on accomplishments from the MITA 2.01 SS-A and provide a high-level vision for programmatic alignment and current systems integration efforts through alignment of the DHHS Strategic plan, Office of MaineCare strategic plan, SIM grant, and how the state intends to reach the overarching goals of meeting the Institute for Healthcare Improvement’s Triple Aim framework and Value Based Purchasing initiatives. These efforts are discussed in further detail in Section E beginning on page 183.²⁵

²⁵ Hyperlinked Crosswalk

SECTION B – HIT “TO BE” LANDSCAPE

This section is the “To-Be” Landscape of the MaineCare HIT program.²⁶ It is divided into two parts:

Part	Description
1. Vision: HIT and Meaningful Use	<ul style="list-style-type: none">a. HIT and Meaningful Use Visionsb. EHR Incentives Program Basisc. EHRIP Integration to SIM Funded Health Homesd. EHRIP Integration in SIM Funded Accountable Care Communitiese. EHRIP-HIE SIM Enabled and Funded Integration
2. 2020 Five Year Plan	<ul style="list-style-type: none">a. Governanceb. Privacy and Securityc. Communication, Education, Outreachd. HIT Initiative Coordinatione. Infrastructure and Systems

Section B. Part 1. Vision: HIT and Meaningful Use

B1a. HIT and Meaningful Use Visions

Health information technology is a cornerstone to Maine’s healthcare transformation plan as articulated in the State Innovation Model plan, that was developed through a multi-stakeholder process. Maine spent a considerable amount of time developing its vision to align with the national vision of the IHI Triple Aim and the state’s movement toward Value Based Purchasing. This SMHP builds on that process through the incorporation of the EHR Incentive’s Program and the implementation of CEHRT and the integration of these program efforts into the overall goals and objectives of the statewide HIT initiatives established under the Centers for Medicare and Medicaid Innovation (CMMI) funded State Innovation Model (SIM) testing grant. Due to the high level of integration with the Meaningful Use Program and various stakeholders involved through the SIM grant initiative Maine has requested a State Self-Assessment under the MITA 3.0 framework as an opportunity to discuss further systems enhancements and integrations within the scope of the Medicaid program. The following are summaries of efforts that are being undertaken to help achieve the statewide HIT visions as they pertain to the EHR Incentives Meaningful Use Program and its’ relation to CMMI funded SIM activities, as well as the continuation of administrative and operational activities solely for the Meaningful Use Program as funded through HITECH. For more information on stakeholder strategic planning goals and objectives, Value Based Purchasing initiatives, or the IHI Triple Aim and the SIM development please refer to Section E beginning on page 183.²⁷

²⁶ See Appendix B-1 for CMS questions posed to states to answer in their SMHP document.

²⁷ Hyperlinked Crosswalk.

B1b. EHR Incentives program Basis: HITECH Act

The Health Information Technology for Economic and Clinical Health (HITECH) Act, enacted as part of the American Recovery and Reinvestment Act of 2009, provided the framework for improving health information technology. The structure of the programs established by the HITECH Act recognizes a federal/state partnership to build the HIT vision to have:²⁸

“A Nation in which the health and well-being of individuals and communities are improved by health information technology.”

The State of Maine strives to continually improve the health of its residents. The State has aligned its strategic HIT vision and goals with those expressed in the HITECH Act and the CMS Medicaid Meaningful Use Programs by adopting a vision anchored in providing or facilitating a system of person-centered, integrated, efficient, and evidence-based health care delivery for all Maine citizens.²⁹

“Preserving and improving the health of Maine people requires a transformed patient centered health system that uses highly secure, integrated electronic health information systems to advance access, safety, quality, and cost efficiency in the care of individual patients and populations.”

Recognizing these essential building blocks as a foundation for its vision to improve the use of HIT to have all Eligible Professionals and Eligible Hospitals achieve Meaningful Use, the MaineCare Program adopted the following vision:

“A Medicaid Meaningful Use Program that leads Maine’s efforts for providers to achieve “Meaningful Use” and is truly integrated into the emerging initiatives designed to achieve the Triple Aim and provide truly integrated, efficient, secure, and high quality health care to MaineCare Members to improve health outcomes.”

B1c. EHRIP Integration to SIM Funded Health Homes

In 2013, building off the Maine multi-payer Patient Centered Medical Home model, the Department provides monthly reimbursement to primary care practices to support MaineCare members with chronic conditions through outreach, preventive health, care coordination, patient and family engagement. The Health Homes Stage A initiative also enables Community Care Teams across the state to partner with these Health Home practices to provide intensive care

²⁸ See CMS Health IT site at <http://www.healthit.gov/policy-researchers-implementers/faqs/how-does-information-exchange-support-goals-hitech-act>

²⁹ See Maine Office of the State Coordinator for HIT October 2010 approved State HIT Plan and the MaineCare SMHP and IAPD and IAPD-U documents available at: www.maine.gov/dhhs/oms/hit/index.html under the Maine’s approved SMHP and IAPD file.

management and community supports to the highest need patients at the practices. Please click on the document below for the Stage A Health Home Year 1 Report³⁰:



HHReport_Yr1_Stage A_FINAL (2).pdf

In spring 2014, Stage B Behavioral Health Homes (for individuals with serious mental illness or serious emotional disturbance) was implemented. Practices that apply and qualify are eligible to participate in both Stage A and Stage B Health Homes. Behavioral Health Homes are an important component of Maine's Value Based Purchasing strategy (detailed on page 185)³¹, a multi-pronged MaineCare initiative designed to improve the healthcare system, improve population health, and reduce cost. Behavioral Health Homes are a partnership between a licensed community mental health provider (the "Behavioral Health Home Organization" or BHHO) and one or more primary care or Health Home practices to manage the physical and behavioral health needs of eligible adults and children. Both organizations receive a per member, per month (PMPM) payment for Health Home services provided to enrolled members. Behavioral Health Homes build on the existing care coordination and behavioral health expertise of community mental health providers. Maine realizes the majority of behavioral health providers are ineligible for participation in the CMS Meaningful Use program, through the incorporation of program eligible primary care providers into the CMMI funded SIM BHHO (detailed on page 223)³² structure these ineligible behavioral health providers will have access to and the ability to collect information coming from the Meaningful Use Program for better care coordination and overall statewide HIT integration. As seen in the figure below HRSA Funded FQHC facilities are also incorporated into the Health Home model for the same purpose.

³⁰ Document is embedded

³¹ Hyperlinked Cross-reference

³² Hyperlinked Cross-reference

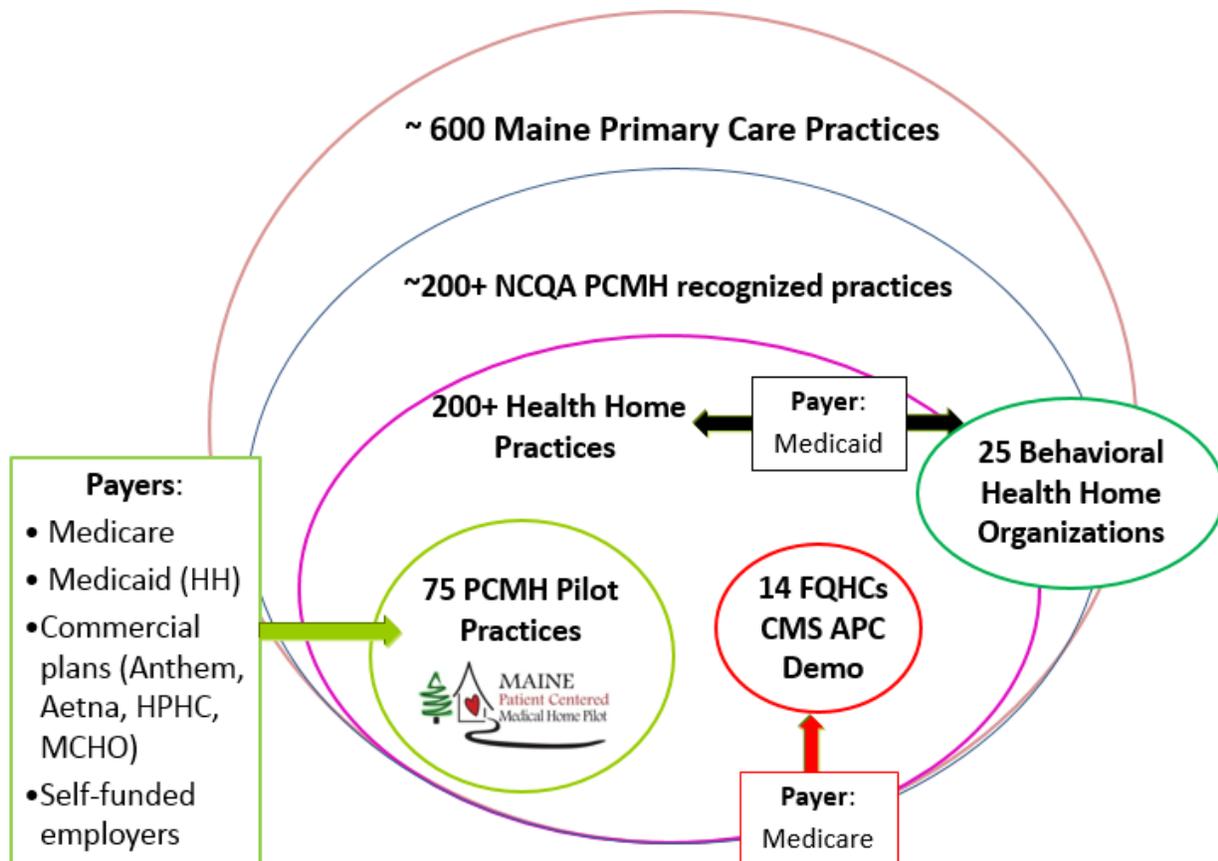


Figure 9 - Maine's Health Home Movement

B1d. EHRIP Integration in SIM Funded Accountable Care Communities

Through Accountable Communities, MaineCare is engaging in shared savings arrangements with provider organizations that, as a group, coordinate and/or deliver care to a specified patient population. Accountable Communities that demonstrate cost savings, as well as the achievement of quality of care standards, share in savings generated under the model. This initiative is currently offered statewide as a Medicaid State Plan option.

Accountable Communities will achieve the triple aim of better care for individuals, better population health, and lower cost through four overarching strategies:

- Shared savings based on quality performance- Accountable Communities will benefit from a Value-Based Purchasing strategy that supports more integrated and coordinated systems of care.
- Practice-level transformation- Accountable Communities will align with and build on the principles of Maine's multi-payer Patient-Centered Medical Home (PCMH) Pilot and MaineCare Health Homes Initiatives.
- Coordination across the continuum of care- Accountable Communities will ensure the coordination of primary, acute, and behavioral health care, as well as long-term services and supports. This includes leveraging the Maine Department of Health and Human Services' existing investment in care coordination for members with chronic conditions, behavioral health needs, and long term services and supports needs.

- Community-led innovation- Local health care needs, resources, and solutions will drive Maine's Accountable Communities. While each Accountable Community will meet baseline criteria, report on core quality measures, and be responsible for the cost of a set of core services, they will also be encouraged and afforded flexibility to structure services and solutions that fit locally-identified priorities and context.
- Integration of the MaineCare Meaningful Use Program to Leverage Opportunities and Improve Health Outcomes.

B1e. EHRIP-HIE SIM Enabled and Funded Integration

B1e1. SIM MaineCare Notification Project /Emergency Room and Inpatient Notifications

Currently in 2015, MaineCare Care Managers receive Emergency Department (ED) and inpatient discharge summary reports for their members from the treating hospital via fax as requested. HealthInfoNet (HIN) is automating this process between the hospitals and MaineCare, on the hospitals behalf, using the Health Information Exchange. HIN is providing MaineCare Care Managers real-time electronic "notifications" using secure email of these events of care. Additional functionalities are being built to assure that this new electronic process creates a more efficient workflow for both the hospital and MaineCare staff while supporting MaineCare member's best possible care.

B1e2. SIM HIE Behavioral Health Home HIT Reimbursement Grant

In May of 2014 the Behavioral Health Information Technology Reimbursement Initiative was launched with the initial 20 BH organizations from across the state of Maine. HealthInfoNet (HIN) uses SIM funding to support behavioral health organizations with reimbursements towards improving Electronic Health Records technology and participation in health information exchange (HIE). HIN is also supporting behavioral health organizations in their measurement of quality of care using their interoperable data. The goal is to add up to 20 new behavioral health organizations to HIN's HIE by 2016. Of the participating organizations all regions of the state are represented: South, East/North, and Central/West. Approximately 90,000 patients are served annually by the participating organizations. Milestone payments were paid out by the end of the 3rd quarter, September 30th, 2015, in the total amount of \$590,000. The initiative holds required monthly webinar's and weekly technical calls to provide milestone information and education towards achieving the milestones.

B1e3. SIM Behavioral Health Home HIE Integration

HealthInfoNet aims to connect all twenty Behavioral Health organization's medical records systems to begin to collect data to incorporate into the current HIE which has been limited to non-behavioral health data. HIN has seven active BH HIE connections in place. The first BH EHR vendor completed bidirectional HIE testing and completed production validation in the 2nd quarter of year 2 to go-live with BH data sharing for the first time in Maine. As the sites participating in the Reimbursement Initiative are connected and begin to share data via a

bidirectional VPN connection, the accountability targets of 15 BHH connected to the HIE will be accomplished in SIM test year 2.

As of FY15 Q3, in supporting the work of BHH organizations connecting to the HIE, MaineCare has reported that they are in the process of providing quality data to BHH organizations that will be accessible through the provider portal. They have also begun to work on a BH workforce development sustainability plan and a series of internet modules aimed at helping BH providers engaged in the work.

B1e4. SIM MaineCare Clinical Dashboard

HealthInfoNet (HIN) has developed and will provide a "Clinical Dashboard" to MaineCare using their member's information available in the Health Information Exchange (HIE). The goal is to make predictive scores, using HIE clinical data, available to MaineCare as a payer to support program and policy development related to population health efforts.

As of FY15Q3, HIN has delivered the initially scoped dashboard tool to MaineCare, which has begun the process of training staff and providing feedback. When the dashboard is completed it will combine current real-time clinical HIE data with MaineCare's claims data. This tool is currently in the testing phases and is the first test of Maine's HIE to support a payer using clinical electronic health record data.

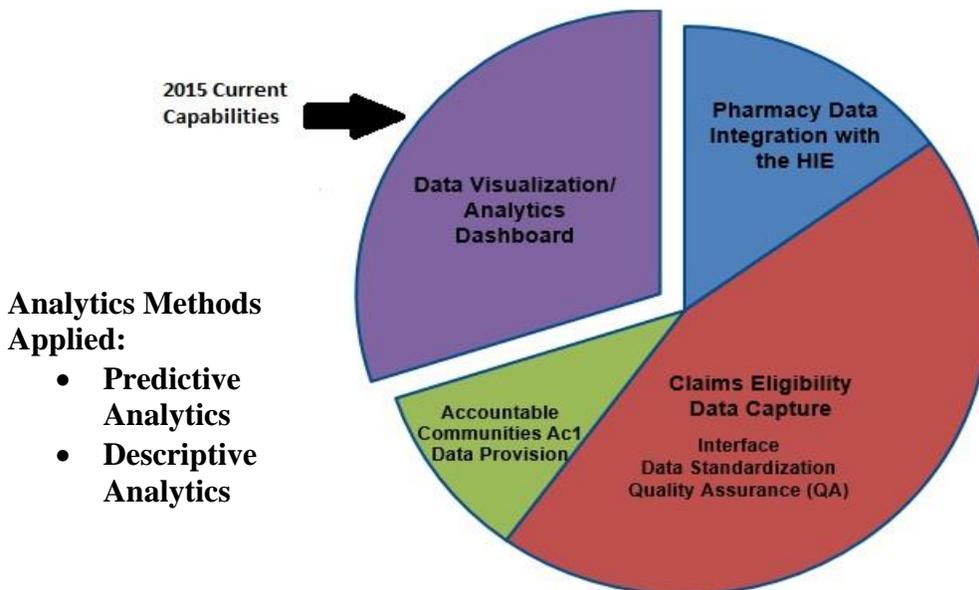


Figure 10 - MaineCare Dashboard Project

B1e5. SIM HIE Patient Portal Pilot

HealthInfoNet partnered with one Health Information Exchange (HIE) health care organization (Eastern Maine Healthcare Systems) to provide their patients with access to their statewide Health Information Exchange (HIE) record for a 6-month period in 2015. The pilot site connected their current "Patient Portal" to the HIE to allow patients to download a medical

record summary document from the HIE known as the "Continuity of Care Document" (CCD). Final results of the pilot are being reviewed by Eastern Maine Healthcare and HIN to determine next steps.

Section B. Part 2. 2021 Five Year Plan

To help realize its Medicaid HIT vision, MaineCare has developed a "To-Be" Landscape which includes the following Parts: 1. Governance; 2. Privacy and Security; 3. Communication, Education, and Outreach; 4. HIT Initiative Coordination; and 5. Infrastructure and Systems.

B2a. Governance

Goal

The Medicaid HIT Program will operate under a governance structure that is collaborative, integrated, and coordinated with DHHS health information technology initiatives with the Office of MaineCare Services.

Activities to Accomplish Goal

For the period through 2020, the MaineCare HIT Program will be housed within the Office of MaineCare Services within the Department of Health and Human Services

In 2011 a key component of the OMS HIT Program planning was to establish a governance structure that would also support the development of the Statewide Office of the State Coordinator HIT Strategic and Operational Plans and other HIT initiatives. Since that time the nature of the relationship has been redefined and the OSC and MaineCare MU Program have been joined with MaineCare maintaining focus on Meaningful Use Projects and the OSC working to bring about coordination on focus on non-MU projects.

Given that the overall structure of HIT planning has changed since 2011 due the incorporation of Meaningful Use into the SIM program, the Meaningful Use Program is overseen by the Deputy Director of MaineCare and is incorporated into the following SIM leadership, steering, and subcommittees which drive the overall vision and advancement of HIT initiatives as defined by the statewide SIM initiative, for further details on how the MU Program is incorporated into the SIM governance structure please refer to Section E page 210.³³

³³ Hyperlinked Crosswalk

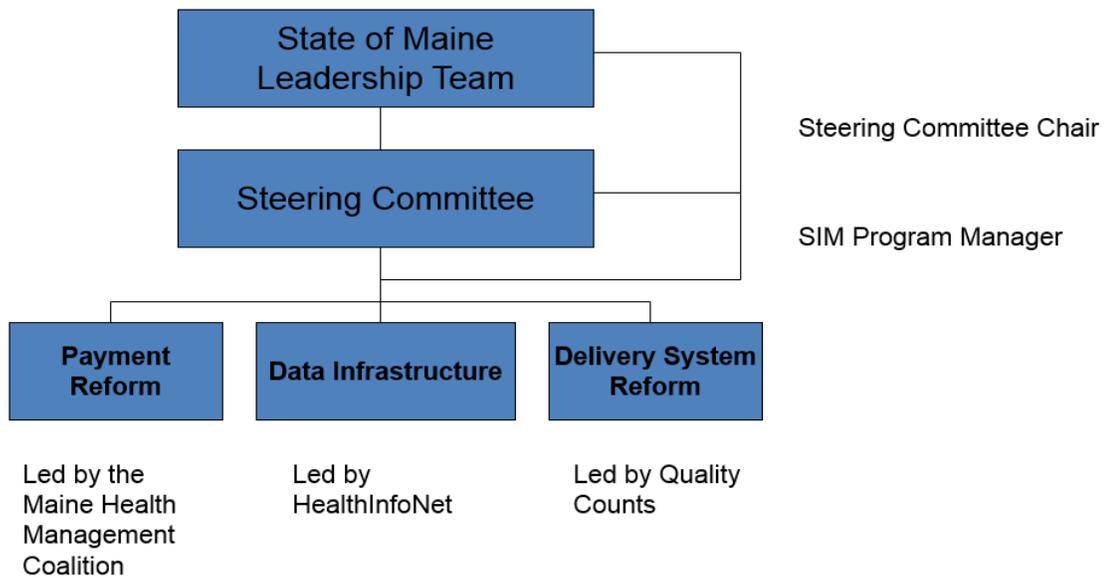


Figure 11 - SIM Governance Structure

For the purpose of day to day programmatic operations of the MU program the Deputy Director of OMS reports to DHHS Commissioner who in turn reports directly to the Governor. The technical systems needed to implement the OMS HIT program are being designed and implemented by the State’s OIT Office. Maine recognizes that the technical system design and development must run in concert with the program and policy development. Important coordination is accomplished through this integrated organizational framework design.

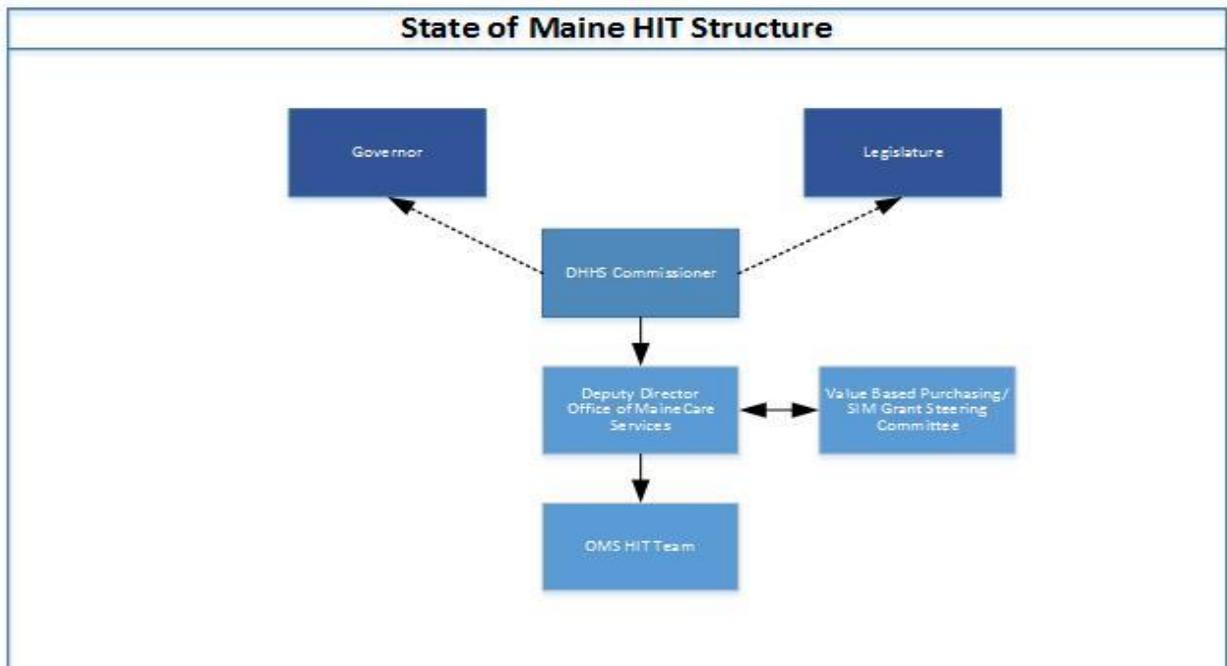


Figure 12- State of Maine HIT Structure

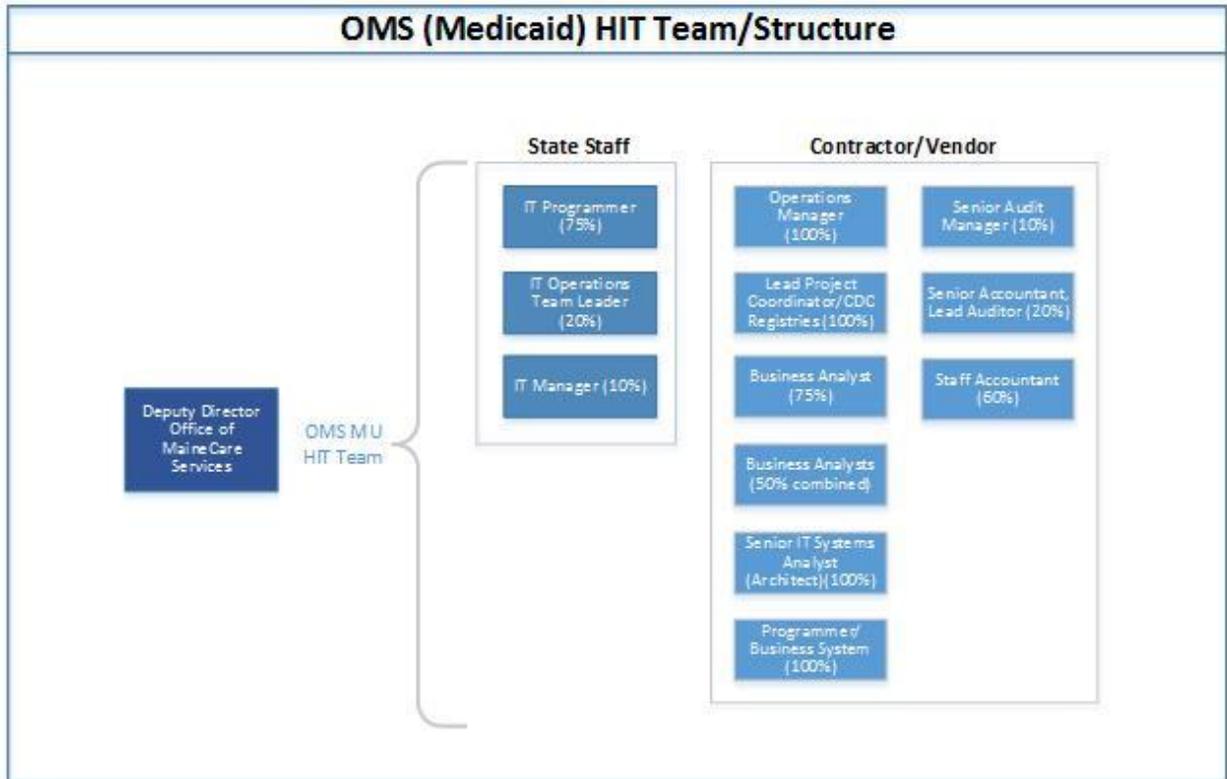


Figure 13 - OMS HIT Team/ Structure

As depicted in the charts, the OMS HIT Program Team is led by the Deputy Director of OMS and a fulltime contracted team of HIT specialists. Team membership also includes part-time permanent Department managers and professionals. The team also consists of full-time OIT staff who design, develop, test and implement the technology necessary to operate the HIT program.

The Deputy Director oversees the program and operations of the OMS HIT program. The MU Operations Manager coordinates and conducts outreach efforts for provider training, escalating issues to CMS for response and guidance, budget and plan program activities, submits quarterly and annual reports to CMS, responds to provider inquiries regarding the EHR Incentive Program, reviews and determines eligibility for the program, analyzes and processes EHR incentive payment requests, track appeals and auditing activities. Business analyst will have primary responsibilities for updates to the SMHP and IAPD.

The OMS HIT MU Program operates under a work-plan framework that was developed during the SMHP planning process. The work plan guides weekly HIT management team meetings with the Deputy Director of MaineCare Services, Program Operations, Office of Information Technology and includes representatives from finance and audit, as needed, to discuss the status of projects and ground level issues that need coordination for day-to-day program operations.

B2b. Privacy and Security

One of the most significant challenges facing HIT initiatives today is addressing the privacy and confidentiality issues raised by the public. The HITECH Act requires more stringent and greatly enhanced privacy and security of patient health information. It strengthens the Health Insurance Portability and Accountability Act of 1996 (HIPAA) by adding new requirements for privacy and security for health information and directly affects more entities, businesses and individuals in more diverse ways.

The underlying HIPAA law layered with the new HITECH Act requirements, require states to conduct a complete inventory of existing privacy and security plans and to make systems and practice improvements which are especially critical to HIT use. Maine viewed privacy and security practices at three levels:

- I. Personal health information that is currently collected electronically and via paper based methods represents an individual's medical history. This must be the most restrictive in terms of access and security and privacy controls. The consumer/individual must have ultimate control over the use and access of this information.
- II. General health information that is found in medical records and is shared among providers. Security and privacy controls must be in place for general medical record information that is controlled by providers. Use of this data should be used for decision-making purposes and so providers can better coordinate care. Since personally identifiable information is still linked to this data, Members must have the choice about what information is shared and who has access to it.
- III. Population health information that is collected and exchanged via an HIE. Other agencies will have access to this information for trending and analysis of general population health. Personally identifiable information is not tied to this data yet privacy and security are still important.

After inventorying and reviewing privacy and security standards and requirements, MaineCare developed the following vision, goal and activities to support its initiative:

Vision

MaineCare will build public trust and enhance participation in HIT and electronic exchange of protected health information by incorporating privacy and security solutions and appropriate legislation, regulations, and processes in every phase of its development, adoption and use.

Goal

By 2019, MaineCare will facilitate electronic exchange, access, and use of electronic protected health information, while maintaining the privacy and security of patient, provider and clearinghouse health information through the advancement of privacy and security legislation, policies, principles, procedures and protections for protected health information that is created, maintained, received or transmitted.

Activities to Accomplish Goal

- The State will continue to work with stakeholders to perform a feasibility study of how to integrate Part 2 data in the exchange of health information.
 - Continued outreach and education will be performed to demonstrate to patients and providers the benefits of HIT and the appropriate exchange of data.
 - Additional legislation, as needed, will be introduced to further the privacy and security of data.
 - The Department, through its Director of Privacy and Security, will continue and will improve the implementation and continued adherence to HIPAA and other privacy and security laws, through its regularly scheduled privacy meetings and updates to security laws.
-

MaineCare has worked diligently in this area and will continue its work for the duration of the program. The OSC formed a Legal Working Group (LWG) in 2009 to address the legal and policy domain requirements in the State HIT and Medicaid HIT Program Plans. The LWG had representatives from the National Association of Mental Illness of Maine (NAMI-ME), HIV providers and advocates, the Maine Hospital Association, the Maine Medical Association, Maine Family Planning, the Attorney General's Office, HealthInfoNet, the Maine Civil Liberties Union, private health attorneys, and the Program Manager of the OMS HIT Program. The LWG analyzed Maine and other state's laws; policies and procedures that enable and foster information exchange within and outside the State; the use of existing or new trust agreements among parties that enable secure flow of information; and how the State addresses issues of non-compliance with Federal and State HIT laws and policies.

The LWG met for six months in 2009 and produced a draft report for the Legislature who recommended that the LWG continue its efforts and report back with proposed legislation. Throughout most of 2010 the LWG worked to draft a report to the Maine legislature which includes draft statutory language to improve Maine laws.

Currently the protection of health information is handled through the DHHS Director of Healthcare Privacy who serves as our Department's Privacy Officer, and our offices have Privacy and Security Officials or Privacy Liaisons who work to follow state and federal healthcare privacy laws, including the Health Insurance Portability and Accountability Act of 1996, or HIPAA. HIPAA does not apply to all of Maine's offices or programs, but when it does, we assure that all requirements are met. There are steep penalties for failing to comply with the law. Even if an office does not fall under HIPAA, the Department still strives to implement reasonable safeguards to protect the information of the individuals we serve.

The Department implements and updates confidentiality policies, procedures, training and forms that the law requires for us to keep health information protected, whether that information is part of a conversation, in a paper chart, or part of an electronic record. Only the minimum health information necessary to conduct business is to be used or shared. Additionally, we only enter into agreements with other organizations to help us with our business processes if they agree to safeguard the information as the law requires.

Maine DDHS will also investigate any possible breach of patient or client data that happens at a Department office or with one of our vendors or business associates. If an actual breach occurs,

the Department will contact individuals whose information is at risk, and report the breach to government regulators.

B2c. Communication, Education and Outreach

The HITECH Act envisions a health care system where individuals can exercise choices and make informed decisions about their health care providers and can allow providers to have access to a patient's "complete" medical record. Decision makers have access to the right information at the right time and the health care delivery system is more efficient and affordable. Maine understands that transforming health care systems to achieve these objectives takes a lot of communication, education and outreach across the State. The topic of public engagement was discussed at length at the HIT visioning sessions where the vision, goals, and activities were developed:

Vision

MaineCare will aid in transforming the current health care delivery system into a high performing health information exchange system by establishing and implementing robust communication, education, and outreach plans to promote wide-spread EHR, Meaningful Use, and exchange among MaineCare providers and inform Members about the benefits of health information technology.

Goal

Continuing its work through 2021, MaineCare will have highly promoted the national and State HIT efforts to improve health outcomes through the use of electronic health information tools by developing and implementing comprehensive communication and training programs for State decision makers, staff, providers, citizens of Maine and stakeholders, and the promotion of exchange and sharing PHI where appropriate, to make informed health care decisions.

Activities to Accomplish Goal

- To date the State's Meaningful Use Program conducted extensive communication strategies that assisted providers in understanding the HITECH Act, Meaningful Use requirements, and the benefits of HIT for the providers as well as the patients. The methods employed included reference and links to the CMS HIT websites; in-person provider forums; webinars; conference calls; participation in provider organization events; written literature; and one-on-one discussions and site visits. Groups involved with the communication have included the State's REC (which is no longer active), Maine Quality Forum, Primary Care Association, Hospital and Provider Associations, consumer groups, Maine's APCD, Maine's State-wide HIE, and the like.
- The State will continue outreach and training programs for DHHS decision makers, MaineCare management and State staff so that they may educate providers and Members about the benefits of HIT and provide Member education on HIT to empower them to effectively make decisions about their health information in an informed manner.

- In 2013, in cooperation with the State’s Broadband Agency, MaineCare conducted a Medicaid provider survey to update and build upon the late 2010 baseline assessment of EHR use among providers. The survey results are being used to conduct outreach and education on the goals, objectives, and benefits of EHR and Meaningful Use initiatives, and how to leverage other sources of funding available for HIT efforts.
 - Maine needs to continue its collaborative efforts among State agencies and stakeholder organizations to further promote the use of tele-health which is greatly needed given Maine’s rural nature and the aging populations. To fully take advantage of tele-health and other emerging technologies, Maine must continue its efforts to provide a communications/broadband structure that provides access to high-speed internet services that are capable of providing home monitoring and the provision of mental and physical health services, needed for “aging in place” goals.
-

The 2013 data from the annual [National Ambulatory Medical Care Survey](#) is encouraging:

- Nearly 80% of office-based physicians used some type of electronic health record system, an increase of 60 percentage points since 2001 and nearly double the percent in 2008 (42%), the year before the Health Information Technology and Economic and Clinical Health Act passed as part of the Recovery Act in 2009.
- About half of office-based physicians surveyed said they use a system that qualifies as a “basic system,” up from just 11% in 2006.
- Almost 70% of office-based physicians noted their intent to participate in the EHR incentive program.

As part of the “As-Is” 2013/2014 Assessment, MaineCare in collaboration with the ConnectMe Authority commissioned a series of surveys of providers, the comprehensive health care provider survey was designed to collect information on E H R use and for the first time, tele-health and high-speed broadband use and capabilities. The survey results were comparable to the data gathered from the 2013 National Survey citing that 79 percent of respondent health organizations exhibit heavy computer use (68% almost all of the time; 11% most of the day, almost every day). Only 1 percent indicated they had not used the computer at all in the previous week, and 2 percent indicated that they had no computer at the practice location and that the availability of new online healthcare technologies, such as the HIE, electronic health records (EHRs), e-prescribing, and telemedicine systems, are considered major drivers of high-capacity broadband connectivity among Maine’s healthcare organizations.

On a parallel track, both data from the Maine ConnectMe Survey as well as data from the 2013 national survey in the ONC’s 2014 Annual Report to Congress show similar barriers for interoperability and a lower priority around non-eligible providers under the EHRIP. MaineCare’s former 2011 visioning sessions with Members and advocates included privacy and security issues and the best means of educating the public about privacy and security safeguards and Maine’s data warehouse and exchange that had adopted opt-in/opt-out strategies for health information, particularly the practice of not exchanging or storing sensitive health information

such as behavioral and mental health, substance abuse and HIV/AIDS records unless the patient specifically opted-in. This opt-in method has been incorporated into DHHS policy surrounding the privacy and security of confidential health information.

Once Maine understood the barriers as perceived by the providers and the public MaineCare was able to develop an “overcoming barriers” communications strategy. For providers, in terms of costs, it means education about the incentive payment programs offered as part of the HITECH Act. For the public, it means education around privacy and security laws, systems, and the benefits of integrated care.

Maine’s strategy for its SMHP is to leverage CMS and ONC guidance and education tools that provide a consistent and comprehensive framework for the HIT programs. MaineCare views the federal program information as being the foundation with Maine-specific information added to the foundation for those aspects of the HIT program that need to be dealt with at the state level. Relying on this approach will serve Maine well as it implements the SMHP because it will result in a program that is consistent with other state HIT programs where it needs to be, and yet recognizes the Maine-specific aspects of HIT initiatives.

The State knows that it will take a variety of communication, education and outreach methods to get program information out to providers and hospitals. As part of its planning activities MaineCare:

- Developed an HIT webpage that is updated regularly, the site has links to the federal HIT program webpage and Maine-specific information such as power point presentations, fact sheets, frequently asked questions, other organization information, calendar of events, OMS contact information, and other postings.
- The MaineCare MU program, developed a communication plan and outreach strategy to advance the use of EHR technology systems and to help qualified health care providers implement and meaningfully use health information technology including electronic health records. This strategy and plan will continue to be updated as MaineCare’s MU program moves forward.
- MaineCare’s MU program has worked closely with independent providers as well as partnering with large health care systems to expand the use of health information technology to affiliated practices. MaineCare’s MU program has continued to move forward as Stage 2 was implemented; we are now putting in place the changes for the modified set of Stage 2 measures which will ultimately lead to reduced reporting burden, eliminate redundant and duplicative reporting, and to better align the objectives and measures of meaningful use with the Stage 3 requirements.
- Participated in the Quality Counts webinars that discuss HIT topics such as the cultural of health care practices, workflow analysis, workflow redesign, vendor selection, implementation optimization, meaningful use, quality improvement and quality coaching.

- Led discussions with provider groups and associations about the barriers, benefits, public engagement, and opportunities for incentive payments.
- Employed existing communication channels (such as MaineCare’s website and Newsletter, MaineCare Matters).

MaineCare will continue these efforts for the duration of the HIT Incentive Payment Program. In addition, Maine agrees with the provisions of the HITECH Act and CMS rules and guidance stressing the importance of an integrated communications and education strategy. Maine will use the comprehensive communication, outreach, and education tools developed by CMS and the ONC for states, providers, and the public. There are several other initiatives in Maine related to health information technology. The State believes that it is critical to coordinate and integrate communication strategies to take advantage of economies of scale, resources, and as important, to avoid fragmented programs that frankly, can be a barrier in and of itself, to health information technology. Maine’s Communication, Education and Outreach activities are best described in the context of “HIT Initiative Coordination.”

B2d. HIT Initiative Coordination

MaineCare is committed to addressing the needs of underserved and vulnerable populations such as children, individuals with chronic conditions, Title IV-E foster children, individuals in long-term care settings and the aged, blind and disabled. To meet this commitment, MaineCare optimizes the coordination of HIT initiatives.

The major coordination points are with the following partners:

Office of the State Coordinator	The OSC has been assimilated into the the DHHS organizational structure, the OSC efforts have been linked to the MaineCare HIT initiative to bring about coordination and focus with projects outside of MU to fit the MaineCare HIT initiative into the larger State-wide HIT plan.
ConnectME Authority	MaineCare is coordinating with the ConnectME Authority, which is responsible for mapping and funding the development of broadband access across the state, to enable access to EHR and to share data in a secure manner.
Maine CDC and the State of Vermont	MaineCare is a partner with Maine’s CDC and Vermont on a newly awarded Children’s Health Insurance Plan Reauthorization Act (CHIPRA) grant that has a large HIT component.
DHHS Initiatives	MaineCare is coordinating with other Federally supported initiatives such as ICD-10, rural Maine Tele-health, and Health Care Reform initiatives.

HealthInfoNet	MaineCare participates in a variety of SIM enabled program and integration activities and data analytic efforts. Including Health Home initiatives and the implementation of the MaineCare Clinical Dashboard.
Patient Centered Medical Home Project	MaineCare participates in a State-wide Patient Centered Medical Home project which has adopted HIT goals and activities.
Partnerships	MaineCare aligns and coordinates its quality measures and programs with Maine Quality Counts and the Maine Quality Forum; and views CMS a critical partner in a successful HIT efforts.

In Maine HIT Initiatives share governance structures (including people who are on the steering committee of the various initiatives), stakeholder relationships, legal and contractual agreements and communication efforts. For example, the OMS HIT Program and the CHIPRA Quality Measurement activities have aligned four CHIPRA core measures with Meaningful Use measures. A complete list of HIT-related grants, including a description of the grant product and how it supports the adoption of EHR technologies, may be found in the “As-Is” Assessment section of the SMHP and the Implementation Advanced Planning Document (IAPD). To support and further this coordination, MaineCare’s visioning activities arrived at a vision, goal and activities:

Vision

Recognizing the benefits of improved health outcomes and program cost efficiencies that a multi-dimensional approach to HIT may afford, MaineCare will realize increased efficiencies related to business processes and systems integrations that allow access to patients, caregivers, and clinical care coordinators and monitoring of patient care, through the coordination of Federal, State and DHHS-specific HIT initiatives and reporting mechanisms as defined by the MITA 3.0 Framework.

Goal

By 2019, all Federal, State and DHHS-specific HIT initiatives will be intrinsically linked through alignment and coordination of plans and clinical quality measures used to improve health outcomes for MaineCare beneficiaries, using data and technology standards as defined under the MITA 3.0 Framework to enable MaineCare to fully inform and provide the essential data needed to meet Triple Aim goals.

Activities to Accomplish Goal

- Use the inventory of initiatives that was gathered for the SMHP planning activities to ensure the MaineCare HIT Program vision and goals to align with the other HIT initiatives and vice versa and ensure that these visions fall in line with the CMS MITA Framework.
- Work to identify and remove barriers for provider adoption and health

information exchange.

- Participate in planning and implementation efforts of the other initiatives, including communications, sharing and exchanging data and information, long-range goals, and governance structure and vice versa.
 - Hold regularly scheduled meetings with the other HIT initiative groups with standing agenda items such as avoiding duplication of efforts, improving efficiencies, upcoming communications and education forums, sharing information, and systems updates that may provide common efficiencies and opportunities for other initiatives to participate in and benefit from.
 - Through coordination with the HIT initiatives and stakeholders, plan and conduct State-wide HIT summits that bring together stakeholders, including providers and Members, to provide education on implementing and deriving benefits from HIT and electronic health records.
 - Similar to the process to develop this SMHP, include other HIT initiatives and stakeholders in the annual (or as needed) SMHP and IAPD updates.
 - Fully integrate, share, and analyze the quality measures from all HIT initiatives and use the results to further improve program delivery and health outcomes.
 - Conduct joint surveys and use other methods to gather provider, Member, public and decision-maker opinions and input to measure the success of coordination and integration of the HIT initiatives.
 - Leverage the CMS and ONC support that is available for states to plan and implement successful HIT programs.
-

B2e. Infrastructure and Systems

The technical infrastructure and systems must support the implementation of the EHR Incentive Program and advance the long-term HIT vision. Maine has an OIT (Office of Information Technology) vision for all DHHS applications that has been reviewed and recognized by DHHS executive management as setting standards for OIT work. The 2014 OIT vision is people, process, and technology. OIT will continue to evolve as an organization using these three pillars to work with agency partners, and outside partners and government organizations, to minimize risk (cyber security, disaster recovery), to ensure stable, cost-effective platforms, and provide technical solutions through project management best practices. The OIT technical requirements and system design to support the MaineCare's EHR Incentive Program and advance the long-term HIT vision provide the basis for Maine's HIT vision, goal and activities for interoperability:

Vision

The MaineCare MU program will advance the provision of services that are client-centered to improve health outcomes, quality, patient safety, engagement, care coordination, and efficiency of the health care system and

reduce operating costs by eliminating duplication of data costs through promoting adoption and Meaningful Use of health information technology, and adherence to the CMS MITA Framework.

Goal

By 2019, all MaineCare Members will be managed by DHHS and providers who have secure access to health related information within a connected health care system using data and technology standards that enable movement of electronic health information to support patient and population-oriented health care needs and which meet Meaningful Use requirements.

Activities to Accomplish Goal

Create a single point of entry for providers and a common identifier to the State's systems for quality, cost efficiency, analysis and research purposes and ultimately connect to the Health Information Exchange by creating a two-way data flow to and from State systems such as:

- MIHMS- Claims Database
- IMMPACT 2- Web- based Immunization Information System
- HealthInfoNet – Maine's Health Information Exchange
- Create a simple, streamlined and automated process for Providers to report Meaningful Use criteria, quality measures and obtain EHR incentive payments;
- Make available all health information (including mental health, substance abuse, HIV and other protected health information, medications and diagnoses) to all MaineCare Members in an easy to understand format;
- Use a common individual identifier (e.g., Master Client Index) technology for continuity of care for individual MaineCare Members and for linking Member information with other Maine Departments such as Corrections and Education;
- Remove data silos from State systems to provide access to the data that is collected and managed commonly across DHHS;
- Coordinate the clinical quality measures gathered by DHHS to ensure CHIPRA, Meaningful Use, and all other clinical quality measures are coordinated especially for populations with unique needs, such as children;
- Provide patients and families access to their health care data through a Member portal;
- Collect and disburse data in a secure standardized manner to promote evidence-based protocols for clinical decisions.

SECTION C. ACTIVITIES TO ADMINISTER THE EHR INCENTIVES PROGRAM

MaineCare spent a great deal of time defining the processes and activities necessary to administer the Medicaid HIT Program and used the framework that CMS provided for states to develop its “necessary activities” section of the SMHP: 1) Program Registration and Eligibility; 2) Payment; 3) Appeals; 4) Reporting; 5) Communication, Education and Outreach; and 6) State Oversight. MaineCare developed a step-by-step process flow to identify each activity needed to meet EHR program technology and operations requirements and then for each activity, identified specific tasks and technologies to accomplish the activity.

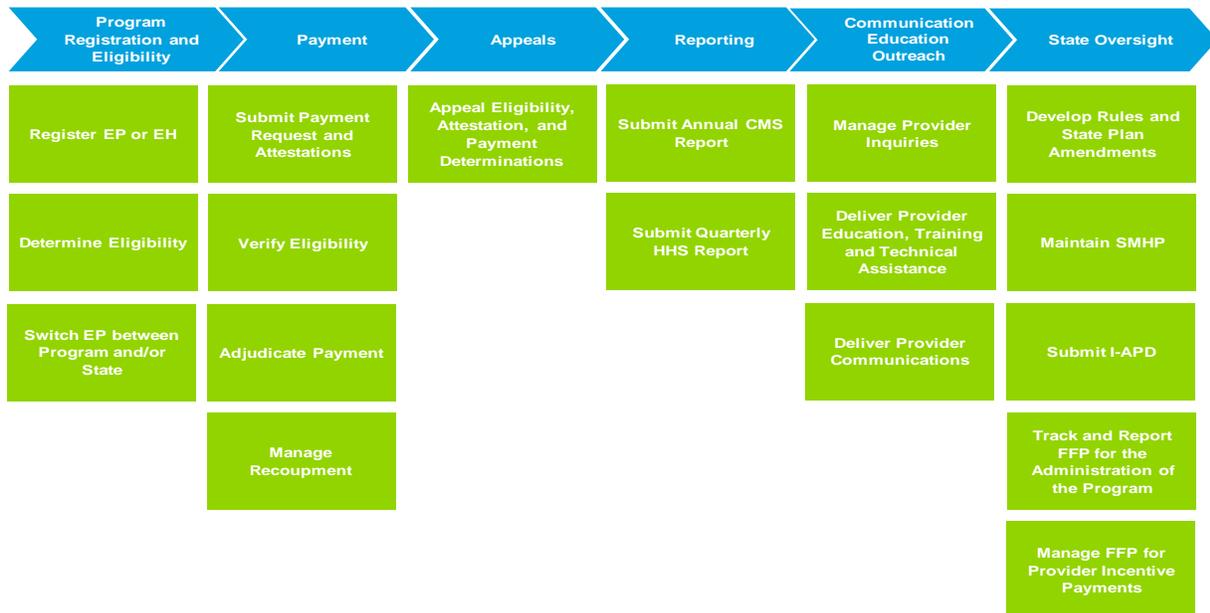


Figure 14 - SMHP "Necessary Activities" Framework

Please see the embedded document below containing the high level process flow for the Activities necessary to administer the Medicaid EHR Incentive Payment Program.³⁴



Maine EHRIP High Level Process Flow v

Section C. Part 1. Program Registration

C1a. Registration at the National Level Registry (NLR)

- EP/EH initiates registration at the NLR for first time program participation
- EP/EH completes all updates necessary in the NLR – change of State, change of payee information, CEHRT information and email contact.
- The NLR will complete an initial check of the EP/EH Medicare /Medicaid enrollment status and a check for exclusions.

³⁴ Embedded document

- The NLR will complete an initial check of the EP/EH Medicare/Medicaid enrollment status and a check for exclusions.
- The NLR will electronically notify the Maine HIT program of registrations EP/EH that choose Maine as the state they wish to continue the application process with by sending the state a B6 file. The B6 file includes the following:
 - Action of B6 –registration added, updated, inactivated, in progress
 - EP/EH registration number
 - EP/EH name and State

****INBOUND** (B6) -- NLR to MAINE EHR/HIT Provider File Complete**

HIT Notification <DO-NOT-REPLY@maine.gov>

• Extra line breaks in this message were removed.

Sent: Thu 10/29/2015 5:00 AM

To: DHHS, EhrHelpdesk

5 TOTAL record(s) added, updated or inactivated via NLR provider file
 P#EFT.ON.NME.REGS4ST.D151029.T0101455 on 29-OCT-15

=====

1 ADDED
 2 UPDATED
 2 INACTIVATED
 0 IN PROGRESS

=====

1 ADDED [Registration # Provider name] (ME)

2 UPDATED [Registration # Provider name]

0 IN PROGRESS

0 RF-Activated

Figure 15 - B6 Notice from NLR to Maine HIT Program

C1b. NLR to SLR Data Feed

The Maine HIT program receives the EP's or EH's registration information from the NLR into the State Level Repository (SLR) via a B6 transaction from the NLR

The following information is included in the B6 notification:

1. Action of B6 –registration added, updated, inactivated, in progress
2. EP/EH registration number
3. EP/EH name and State

The SLR is populated with information from the NLR via the B6. This information is hard coded and cannot be changed by the HIT specialist.

Included data:

1. Registration number

2. NPI
3. TIN
4. Name
5. Address
6. email
7. Program option: Medicaid program
8. EP/EH type
9. Payee NPI
10. Payee TIN
11. Payee Name
12. Entry date of registration

Home > Provider Details

Prior Payments
Payment Year 1

****UAT/TEST-Development Version****
SYSTEM_SETUP - ACTIVE_SYSTEM = UAT
HIT15V350U0101

CMS/National Provider Information:
 Registration ID : 12121212
 NPI : 12121212
 TIN : 001221212 - SSN
 CCN : --
 Provider Name: Debbie Eggplant
 Legal / Business Name : --
 Address : 489 State Street, Kelley 6, Bangor, ME 04401-4840
 Email : gregory.tang@maine.gov
 Program Option : MEDICAID
 Provider Type : MD - Physician

Assigned Payee
 Payee NPI [Redacted]
 Payee TIN [Redacted]
 Payee Name
 Payee Address

Provider Specialties
 No Provider Specialty specified (PECOS-Taxonomy)

Eligibility Information
 Is Hospital **N**
 Entry Date: 09/28/2015
 Application Received: -
 Basic Info Ok: -
 Encounter Ok: -
 Ehr Software Ok: -
 Aiu Attest Ok: -
 Eligibility Status: -

Provider & Basic Information | Eligibility & Encounters | EHR SW | Attestation | Manage Tags | summary
 Payments | External Elements | Subgroups | Chk Payee | Alternate Email Address | < Back

Figure 16 - Screen shot of SLR with B6 information from the NLR

Section C. Part 2. Maine HIT Program Application Process

C2a. Hospital Application Process for the Medicaid Incentive Program

- Medicaid program eligibility requirements for hospitals each program year:
 - Minimum 10% Medicaid encounter threshold. The percentage is calculated from the most recently filed Medicare cost report.
 - Active hospital license from the State of Maine
 - Certified Electronic Health Record Technology (CEHRT) – inpatient system
- Hospital payment calculation:
 - Total hospital payment amount is calculated in the first participation year and will be issued in three annual payments: 50% Payment Year 1, 40% in Payment Year 2, and 10% in Payment Year 3
- EH can choose to apply for AIU with the Maine HIT Medicaid Incentive Program or submit MU to the Medicare program for year one participation.
- Hospital contacts the Maine HIT Program to apply for the Medicaid incentive program
 - Hospital is sent the Medicaid Eligibility sheet

- EH submits the completed worksheet with a copy of the most recently filed cost report, CEHRT data and active license.
- EH submits all MU to the Medicare program through the NLR
- Approval and acceptance of EH MU is done by the Medicare incentive program
- Approved MU is accepted by the Medicaid incentive program as received from NLR
- Hospitals application process continues as described for providers; the worksheet for hospitals and how MU is submitted are items that are different.

C2a1. Hospital Application Process Worksheet

HOSPITAL CONFIRMATION THAT 10% OF INPATIENT DAYS ARE MEDICAID

Note: To complete this worksheet you will need your most recently filed Medicare Cost Report

HOSPITAL NAME:

You will need to confirm (Attest) that you meet the percentage of Medicaid encounters needed to get a Medicaid incentive payment.

	From	To
Enter the beginning date and the end date of the fiscal year you are using to complete this worksheet.		
Enter the total number of discharges (Worksheet S-3, Part I, line 14, Column 15,) Number of total encounters (In-patient days)		
Enter the total inpatient days (Worksheet S-3, Part I, Column 8, Line 1,2 + Lines 8-12		
Enter total Medicaid inpatient days (Worksheet S-3, Part I, Column 7, Line 1 + Lines 8-12		
Automatic calculation of total number of inpatient days that are Medicaid "associated." Number of Medicaid Encounters	#DIV/0!	
Automatic calculation of the percentage of inpatient days that are Medicaid associated (called encounters)	#DIV/0!	
Automatic calculation of the average length of stay (must be 25 days or fewer)	#DIV/0!	

Send completed worksheet and supporting documentation to: EhrHelpdesk.DHHS@maine.gov

Documents to return to Maine for a Medicaid EHR Incentive Payment:

1. This worksheet completed with data from your most recently filed Medicare cost report

2. Documentation for the hospital's CEHRT. Please include all systems that make up the unique CEHRT ID number.

<http://oncchpl.force.com/ehrcert?q=CHPL>

3. A copy of the hospital current license

4. Do you participate in the HIE through HealthInfoNet? - yes/no

C2b. Provider Application Process for the Medicaid Incentive Program

C2b1. SLR Notification to Provider

Once a provider has successfully completed the NLR registration they receive an automated email from the Maine SLR (see Figure 16) with instructions and an attached [Medicaid eligibility worksheet](#).

The 2015 Medicaid Eligibility worksheet includes a link to a [guide](#) that assists the provider to complete the worksheet. The guide includes a description of what is being asked for each section of the worksheet and links to information that the provider will use in the completion of the worksheet.



(UAT TEST)Action Required to apply for the Medicaid Incentive Program.msg

Figure 17 - Provider email from SLR when registration at NLR is successful³⁵

For providers that have participated in the Maine HIT program previously the process to initiate a new program year is done differently than what was done for the first year of participation.

- Providers in program years beyond year 1 will contact the Maine HIT program via email or phone and request that their status be moved to the next program year in the SLR.
- The HIT specialist moves the provider to the next program year in the SLR by selecting “Create a New Payment Year for this provider” (see figure xx)
- The creation of a new payment year automates the SLR to send the provider an email with the Medicaid Eligibility Worksheet attached (see figure xx)

CMS/National Provider Information:	Assigned Payee	Eligibility Information
Registration ID: 100004967	Payee NPI: 1659392819	Is Hospital: N
NPI: 1811954506	Payee TIN: 010179500 - EIN	Entry Date: 11/18/2011
TIN: 281428309 - SSN	Payee Name: WEBBER HOSPITAL ASSOCIATION	Application Received: 12/15/2011
CCN: --	Payee Address: Po Box 626, BIDDEFORD, ME 04805	Basic Info Ok: Y - 12/27/2011
Provider Name: Gregory A Van Gundy		Encounter Ok: Y - 12/27/2011
Legal / Business Name: --		Ehr Software Ok: Y - 12/16/2011
Address: 9 Healthcare Drive, Suite 101, Biddeford, ME 04805-9487		Aliu Attest Ok: Y - 12/28/2011
Email: gregory.tang@maine.gov		Eligibility Status: ELIGIBLE - 12/27/2011
Program Option: MEDICAID		
Provider Type: MD - Physician		

Provider Specialties

Provider Specialty: 16 - Obstetrics/Gynecology

ALERT: This Payment Year (#1) has been CLOSED and PAYMENTS have been DISBURSED

Create a New Payment Year for This Provider

Figure 18 - SLR screen shot for moving a provider to a new program year

³⁵ Document is embedded.



(UAT TEST)Action Required to apply for the Medicaid Incentive Program.msg

Figure 19 - Provider email from SLR after provider is rolled to the next program year with attached worksheet³⁶

The HIT Specialist will work directly with the EP or EH to further explain the requirements of the MU Program and the application process as needed.

The Maine HIT MU program [website](#) has detailed instructions and links that streamline the application and MU submission process and provides multiple resources for providers.

C2b2. Provider’s Medicaid Eligibility Worksheet

C2b2a. Medicaid Eligibility Worksheet - Tab 1

- Name and contact information for the person completing the worksheet

Preparer's Name:	
Best Method of Contact:	
Phone Number:	
E-mail Address:	

Figure 20 - Medicaid Eligibility Worksheet Tab 1- Information for person completing the worksheet

- Provider Name – type in
- 2015 Application Option – choose from
 - AIU 2015
 - Modified Stage 2 with Stage 1 thresholds
 - Modified Stage 2
 - See guide for details
- Provider's NPI Number– type in
- Provider License Type– choose from
 - MD (Medical Doctor)
 - DO (Doctor of Osteopathy)
 - PA (Physician Assistant)
 - NP (Nurse Practitioner)
 - CNM (Certified Nurse Midwife)
 - Dentist
 - See guide for details

Provider Name	2015 Application Option	Provider's NPI Number	Provider License Type
type in <input type="text"/>	(click cell below then drop down arrow to select one option) <input type="text"/>	type in <input type="text"/>	(click cell then drop down arrow to select one option) <input type="text"/>
Dr. A	Modified Stage 2 with Stage 1 thresholds	123456789	MD (Medical Doctor)

Figure 21 - Medicaid Eligibility Worksheet Tab 1 - Provider Information

- Provider Specialty– type in

³⁶ Document is embedded.

- Payee Name– type in
- Assignment of Payment Documentation– choose from
 - Not applicable
 - Yes, I have documentation that supports the provider's assignment of payment to the listed payee
 - See guide for details
 - This satisfies the State that the submitter has retained documentation of the assignment of payment
- Payee NPI– type in
 - See guide for details
- Organization Structure– type in
 - See guide for details

Provider Specialty type in	Payee Name type in	Assignment of Payment Documentation (click cell then drop down arrow to select one option)	Payee NPI type in	Organization Structure type in
Family Practice	XYZ Family Medicine	Yes, I have documentation that supports the provider's assignment of payment to the listed payee	xxxxxxxxxx	Parent: XYZ Healthcare Practice: XYZ Family Medicine
		Not applicable		
		Yes, I have documentation that supports the provider's assignment of payment to the li		

Figure 22 - Medicaid Eligibility Worksheet Tab 1 - Provider/Payee Information

- Provider Service Location– type in
 - See guide for details
- Medicare Payment Adjustment Hardship Exception– choose from
 - Not applicable
 - Provider has applied for a hardship exception but has not yet received CMS approval
 - Provider has applied for hardship exception and has received CMS approval
 - See guide for details – the guide contains a link to the CMS website with information regarding the Medicare payment adjustment
 - This data is entered into the SLR

Provider Service Location type in	Medicare Payment Adjustment Hardship Exception (click the cell below the topic, then drop down arrow to select one option)
XYZ Family Medicine 123 Medical Place Augusta, ME 04333	Not applicable
	Not applicable
	Provider has applied for a hardship exception but has not yet received CMS approval
	Provider has applied for hardship exception and has received CMS approval

Figure 23 - Medicaid Eligibility Worksheet Tab 1 - Service Location, Medicare Payment Adjustment

- FQHC-Federally Qualified Health Center/RHC - Rural Health Clinic Providers– choose from

- Not applicable
- Provider works at an FQHC/RHC and meets the practices predominately definition
- See guide for details – the definition of Practices predominately is included in the guide
- The selected answer is verification the FQHC/RHC providers are meeting the definition of practice predominately
- The provider is required to maintain documentation of this status in the case of an audit

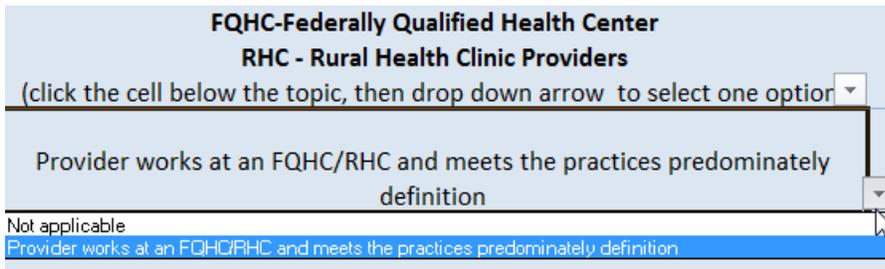


Figure 24 - Medicaid Eligibility Worksheet Tab 1 - FQHC/RHC

- Hospital Based Status– choose from
 - Not applicable
 - 10% or more of my services are outside the inpatient setting; I am eligible for the program
 - 90% or more of my services are hospital based; I am not eligible for the program
 - See guide for details
 - The selected answer is verification from the provider that they are not solely hospital based
 - The provider is required to maintain documentation of this status in the case of an audit

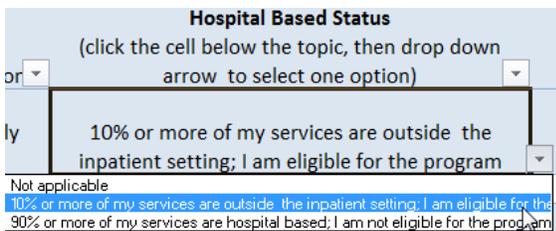


Figure 25 - Medicaid Eligibility Worksheet Tab 1: Hospital-based Status

- Maine's Health Information Exchange (HIE)- type in yes or no
 - Yes/no answer is to answer: Does the provider participate in Maine's Health Information Exchange (HIE) through HealthInfoNet (HIN)?
- AIU or MU– choose from

- A-adopt
- I-implement
- U-upgrade
- MU-meaningful use
- See guide for details

Maine's Health Information Exchange (HIE)	AIU or MU
type in yes or no	(click the cell below the topic, then drop down arrow to select one option)
no	A-adopt
	<ul style="list-style-type: none"> A-adopt I-implement U-upgrade MU-meaningful use

Figure 26 - Medicaid Eligibility Worksheet Tab 1: HIE, AIU or MU

- CEHRT Product Name- type in
- CEHRT Vendor Name
- CEHRT Product Version #
- CHPL Product Number
- Certification ID Number
- CEHRT is 2014 Certified- type in: yes or no
 - See guide for details – included is a link to the CHPL site and a [guide for generating a CEHRT number](#)
 - The submitted CEHRT information is verified at the CHPL site by the HIT specialist
 - The provider is required to maintain documentation of the CEHRT in the case of an audit

CEHRT Product Name	CEHRT Vendor Name	CEHRT Product Version #	CHPL Product Number	Certification ID Number	CEHRT is 2014 Certified
type in	type in	type in	type in	type in	type in: yes or no
athenaClinicals	athenahealth, Inc	14.1	140056R06	1314E01QEXWMEAX	Yes

Figure 27 - Medicaid Eligibility Worksheet Tab 1 - CEHRT

- Medicaid Eligibility Calculation– choose from
 - Individual provider encounters only
 - Practice/Group level encounters
 - See guide for details – included is a [link to a guide](#) to developing the Medicaid Eligibility calculation
 - The provider is required to maintain documentation of Medicaid eligibility status in the case of an audit
- Does the EP practice at more than one practice site? - type in: yes or no
 - See guide for details

- The provider is required to maintain documentation of this status in the case of an audit
- Multiple Site MU Reports Combined - type in: NA, Yes or No
 - See guide for details
 - The provider is required to maintain documentation of this status in the case of an audit
- Comments - type in any comments you feel will be helpful
 - See guide for details

Medicaid Eligibility Calculation <small>(click the cell below the topic, then drop down arrow to select one option)</small>	Does the EP practice at more than one practice site? <small>type in: yes or no</small>	Multiple Site MU Reports Combined <small>type in: NA, Yes or No</small>	Comments <small>type in any comments you feel will be helpful</small>
Practice/Group level encounters <small>Individual provider encounters only PracticalGroup level encounters</small>			

Figure 28 - Medicaid Eligibility Worksheet Tab 1 - Medicaid Eligibility - Calculation Type, Multiple Practice Site, Combined Report, Comments

C2b2b. Medicaid Eligibility Worksheet - Tab 2

MaineCare will apply the State encounter methodology to calculate patient volume thresholds. Maine recognizes and will apply the different threshold requirements based on the type of EP. For example, for an EP to be eligible as an FQHC EP, the EP must practice predominantly in the FQHC and must meet a 30% needy individual patient threshold. Non-FQHCs, (other than pediatricians) must be non-hospital based (90% or less of their practice is done outside the hospital settings as described in the process flow documents included in this SMHP) and must meet the 30% Medicaid patient encounters threshold. Pediatricians must meet a 20% Medicaid patient encounter threshold.

- Individual provider: Medicaid encounter method:
 - Numerator: One provider’s Medicaid patient encounters for a 90 day period
 - Denominator: Total number of all patient encounters in the same 90 day period.
- Practice/Group level: Medicaid encounter and FQHC/RHC/IHS: needy encounter:
 - Numerator: All Medicaid/Needy patient encounters for a 90 day period
 - Denominator: Total number of all patient encounters in the same 90 day period

*Guide provided to provider for calculation of Medicaid eligibility:

<http://www.maine.gov/dhhs/oms/HIT/documents/medicaideligibilityreportingperiodandcalculationoptions.pdf>

- The provider is required to maintain documentation of Medicaid eligibility status in the case of an audit

C2b3. CHIP Encounter Proxy Method

- 1) For Program Years 2011 and 2012, CHIP stand-alone and expansion encounters must be excluded from the eligible encounter calculation. The State uses a proxy method based on the calendar year number of instate CHIP claims divided by the total number of MaineCare claims. The State then subtracts the resulting percentage from the percentage of eligible encounters to make a preliminary determination of whether the EP or EH meets the percentage of Medicaid encounters required for Program participation. The proxy percentage applied for Program Year 2011 is 2.28%; the proxy percentage applied for Program Year 2012 is 2.21%.
- 2) Beginning with Program Year 2013, CHIP stand-alone encounters must be excluded from the eligible encounter calculation. The proxy percentage applied for Program Year 2013 is .75%. The proxy percentage applied for Program Year 2014 is .66%. The proxy percentage applied for Program Year 2015 is .74%. The State will submit an updated proxy amount for subsequent Program Years as they are determined.

Because the State is using an average calculation and it is based on claims, any EP or EH who is preliminarily found to be ineligible for the Meaningful Use Program due to not meeting the Medicaid encounter threshold, will be notified and offered the opportunity to provide specific numbers of actual CHIP encounters and total encounters to determine whether the EP or EH meets the threshold of MaineCare encounters needed for Program participation.

Documentation for Calculating Medicaid Encounters

Note: Please complete all green highlighted areas			
I am using <i>practice level</i> numbers for all of the professionals in the practice	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
The information used for the Medicaid eligibility calculation is from:	<input type="checkbox"/> EHR System	<input type="checkbox"/> Billing Department	<input type="checkbox"/> Billing Services
The 90 day period I have selected for the Medicaid Eligibility Calculation is:	Start Date:	End Date:	

Important: You may choose any 90 consecutive days from the previous calendar year or the previous 12 months before your application date to determine your Medicaid eligibility percentage. The start date does not have to begin on the 1st of the month.

[Click here for Guide to calculating Medicaid Eligibility:](#)

Medicaid Eligibility Calculation - NON FQHC/RHC Providers Individual or Practice/Group Level		
Insert the total for Medicaid and Patient encounters; percentage will auto calculate (see guide for details)		
	Medicaid Encounters	
	Total Patient Encounters	
	Total Percentage Medicaid Patient Encounters	#DIV/0!

Medicaid Eligibility Calculation - FQHC/RHC Needy Calculation			
All providers at an FQHC/RHC must meet the definition of "practice predominantly" (see guide for details)			
Insert the total for type of encounters as indicated; percentage will auto calculate			
Primary Insurance Carrier			
None - Uninsured - Sliding Scale:			
Regular Medicaid			
CHIP Medicaid			
Subtotal Medicaid-Needy		0	
Medicare			
Other Public Insurance			
Other			
Subtotal Public Insurance		0	
Private Insurance			
Subtotal Private Insurance		0	
		Total Encounters	0
		Total Percentage "Needy Individuals"	#DIV/0!
Medicaid Eligibility Preparers Name:			
Best method of contact:			
Phone Number:			
E-mail Address:			
Legal name of Practice:			
Date of Completion:			

You are required to maintain detailed records for the method used to determine the Medicaid Eligibility Calculation. All records must be retained for six years.

If submitting by practice or organization level you are required to include all sites and all providers data used for the calculation. For your convenience you can use this sheet to list sites and provider NPIs if applicable.

Please add any explanations you feel should be included for the clearest way for us to reproduce your calculation.

In addition to listing all sites and providers NPIs used for the Medicaid eligibility calculation you must have documentation that the patients included as Medicaid patients were eligible for MaineCare during the period used for the calculation.

You are not required to submit that data to us at this time but you will be required to provide patient level documentation in the event of an audit.

Practice Name	Practice NPI	Provider Name	Provider NPI	Notes

Figure 29 - Medicaid Eligibility Worksheet Tab 2 - Patient Volume Calculation

C2b4. Maine HIT Program Application Process

C2b4a. Provider Action

- Complete the Medicaid Eligibility Worksheet with provider information and the Medicaid Eligibility calculation
- Return the completed Medicaid Eligibility Worksheet to the Maine HIT MU program via email at: EhrHelpdesk.DHHS@maine.gov

C2b4b. HIT Specialist Action

A HIT Specialist reviews the submitted Medicaid eligibility worksheet and confirms the submission data meets the requirements as set forth in the Final rule including all rule updates:

- Verify the following in the Maine MHIMS System:
 - Provider Name
 - Provider NPI
 - Provider Type
 - Provider association
 - Medicaid Provider Status

The screenshot shows the QNXT Provider Module S481.026.06 interface. The top section is the 'Add Provider' form with fields for Full Name, NPI, State, County, Zip Code, Provider Type, Provider Category, and Specialty Code. Below this is the 'Provider Summary' page, which includes a 'Provider Management' tab and a 'Provider Summary' section. The 'Provider Summary' section contains fields for Name, Universal Provider ID, NPI, Last Name, First Name, Phone, Fax, Federal ID, Initial, Title, Status, and Provider Type (SI-Physician). It also includes a 'Plan Relationships' table and a 'Contracts' table.

Health Plan	Active	Program	Provider ID	Effective Date	Termination Date
DHHS	Yes	MaineCare		01/01/2008	
DHHS	Yes	MaineCare PCCM		01/01/2008	
DHHS	Yes	Medical EyeCare - Discontinued as of 11/7/2011		01/01/2008	
DHHS	Yes	Office of Child and Family Services		01/01/2008	

Program	Contract	Participation	Contracted By	Effective Date
MaineCare	PHYSICIAN I CONTRACT	PAR		01/01/2008
MaineCare	PHYSICIAN III EPSDT CONTRACT	PAR		01/01/2008
MaineCare	PHYSICIAN PCCM UNDERSERVED CONTRACT	PAR		10/01/2012
MaineCare	PHYSICIAN III EPSDT CONTRACT	PAR		01/01/2013

Figure 30 - Maine's MHIMS System

- Verify provider license status via the Maine Regulatory Licensing & Permitting site <https://www.pfr.maine.gov/almsonline/almquery/SearchIndividual.aspx>

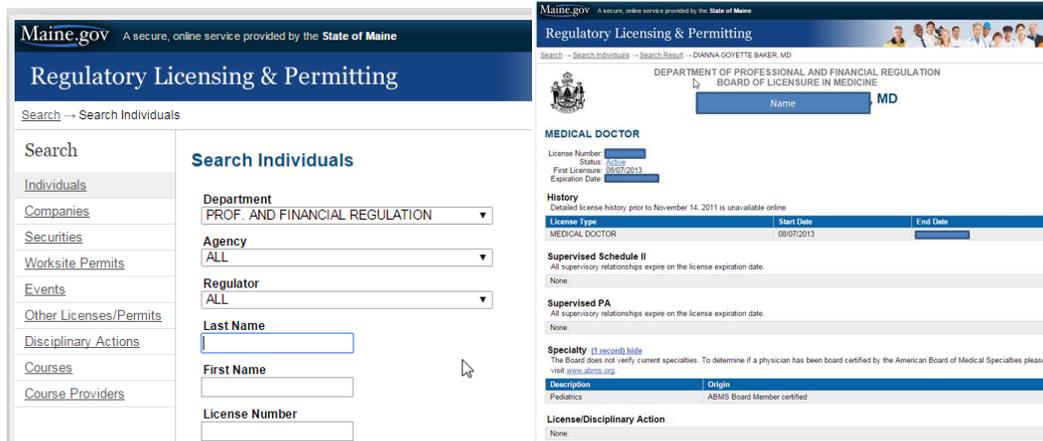


Figure 31 - Verification of provider license status

- Provider Hospital Based status
 - Provider submits status on the Medicaid Eligibility worksheet- accepted as submitted
 - The provider is required to maintain documentation of Medicaid eligibility status in the case of an audit
 - Verification of provider billing and association is done in the Maine MHIMS system by the audit team.

Notice containing the following is included in the [Guide to completing the Medicaid Eligibility worksheet](#): “A provider is considered hospital based when 90% or more of their services are performed in an Inpatient Hospital (code 21) or ER Hospital setting (code 23). Hospital based providers are not eligible for the Medicaid EHR Incentive Program and should not apply. If you are hospital based but additionally perform services greater than 10% outside of the Inpatient or ER setting and have documentation to support those services you are eligible and may apply.”

- Verification that EPs at FQHC/RHC meet the practices predominantly requirement
 - Provider submits status on the Medicaid Eligibility worksheet- accepted as submitted
 - The provider is required to maintain documentation of Medicaid eligibility status in the case of an audit
- Verification of Provider Assignment of Payment
 - HIT specialist will verify:
 - Payee NPI entered on the NLR matches the Payee NPI submitted on the worksheet and the SLR
 - Payee NPI is vendor with MaineCare
 - Payee NPI and Payee are active in MIHMS

Home > Provider Details

Prior Payments
Payment Year: 1

****UAT/TEST-Development Version****
SYSTEM_SETUP - ACTIVE_SYSTEM = UAT
 HIT15V350U0101

CMS/National Provider Information:

Registration ID : 1212121212
 NPI : 1212121212
 TIN : 001221212 - SSN
 CCN : --
 Provider Name: Debbie Eggplant
 Legal / Business Name : --
 Address : 489 State Street, Kelley 6, Bangor, ME 04401-4840
 Email : gregory.tang@maine.gov
 Program Option : MEDICAID
 Provider Type : MD - Physician

Assigned Payee:

111111111
 111111111
 XYZ Family Medicine
 123 Medical Place
 Augusta, ME 04333

Eligibility Information:

Is Hospital: N
 Entry Date: 09/28/2015
 Application Received: -
 Basic Info Ok: -
 Encounter Ok: -
 Ehr Software Ok: -
 Aiu Attest Ok: -
 Eligibility Status: -

Provider & Basic Information | Eligibility & Encounters | EHR SW | Attestation | Payments | External Elements | Subgroups | Chk Payee | Alternate Email Address | Manage Tags | summary | < Back

Figure 32 - SLR interface with hard coded data from NLR

Payee Name type in	Assignment of Payment Documentation (click cell then drop down arrow to select one option)	Payee NPI type in	Organization Structure type in	Provider Service Location type in
XYZ Family Medicine	Yes, I have documentation that supports the provider's assignment of payment to the listed payee	111111111	Parent: XYZ Healthcare Practice: XYZ Family Medicine	XYZ Family Medicine 123 Medical Place Augusta, ME 04333

Figure 33 - Provider supplied information for payee on the Medicaid Eligibility worksheet

NOTE: This Provider has ASSIGNED their payment to another PAYEE NPI

AdvME Vendorcode: VC2179078914

✓ Payee Vendor - OK

➤ All Vendor - Details

Figure 34 - Verification payee NPI is established with MaineCare: SLR

QNXI - Provider Module 5481.026.06 - Windows Internet Explorer

TRIZETTO

Welcome Patricia Chubbu. You are logged on to the environment: ME-PRD

Provider Management > Provider Summary

Name: [Redacted]
 Universal Provider ID: [Redacted] | Provider ID: [Redacted] | NPI: [Redacted] | Active | Credentialed | Memo

Last Name: [Redacted] | Phone: [Redacted] | NPI: [Redacted]
 First Name: [Redacted] | Fax: [Redacted] | Federal ID: [Redacted]
 Initial: [Redacted] | Title: [Redacted] | Status: Active | Incomplete Fed Type: [Redacted]
 Provider Type: 31-Physician | Specialty: FAMILY PRACTICE
 Physical Address: [Redacted]

Plan Relationships

Health Plan	Active	Program	Provider ID	Effective Date	Termination Da
DHHS	Yes	MaineCare		01/01/2008	
DHHS	Yes	MaineCare PCOM		01/01/2008	
DHHS	Yes	Medical EyeCare - Discontinued as of 11/7/2011		01/01/2008	
DHHS	Yes	Office of Child and Family Services		01/01/2008	

Contracts

Program	Contract	Participation	Contracted By	Effective Dat
MaineCare	PHYSICIAN I CONTRACT	PAR	[Redacted]	01/01/2008
MaineCare	PHYSICIAN III EPSDT CONTRACT	PAR	[Redacted]	01/02/2008
MaineCare	PHYSICIAN PCOM UNDERSERVED CONTRACT	PAR	[Redacted]	10/01/2012
MaineCare	PHYSICIAN III EPSDT CONTRACT	PAR	[Redacted]	01/01/2013

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Figure 35 - Verification Payee Entity matches in MIHMS

- Verify the submitted CEHRT information:
 - CEHRT Vendor Name
 - CEHRT Product Version #
 - CHPL Product Number
 - Certification ID Number
 - CEHRT is 2014 Certified- type in: yes or no

- The submitted CEHRT information is verified at the CHPL site by the HIT specialist: <http://oncchpl.force.com/ehrcert>

CEHRT Product Name type in	CEHRT Vendor Name type in	CEHRT Product Version # type in	CHPL Product Number type in	Certification ID Number type in	CEHRT is 2014 Certified type in: yes or no
athenaClinicals	athenahealth, Inc	14.1	140056R06	1314E01QEXWMEAX	Yes

Figure 36 - CEHRT information provided on worksheet

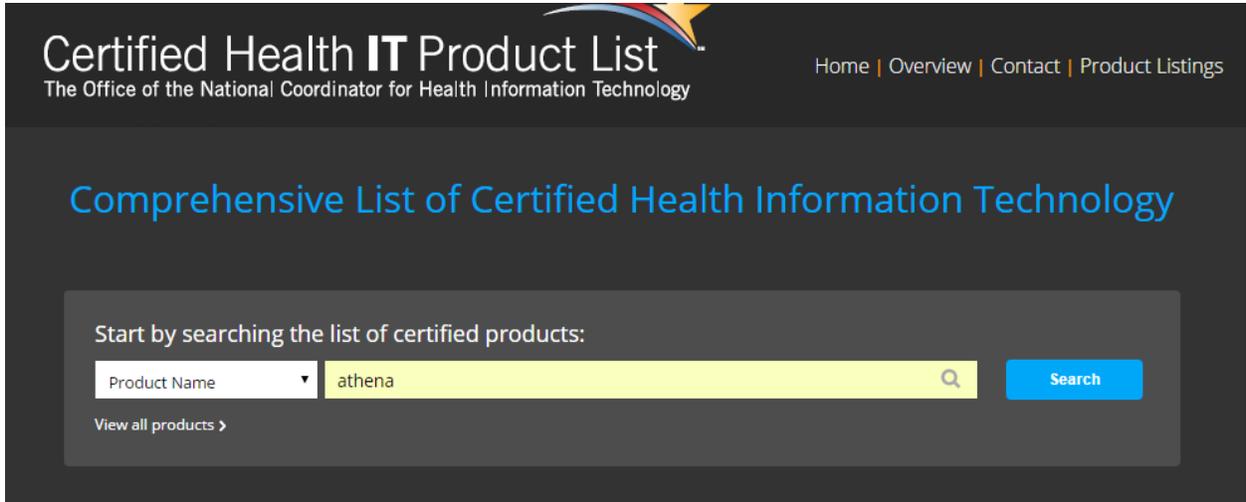


Figure 37 - CHPL site verification of CEHRT: Search by product name

The screenshot shows the search results page on the CHPL site. It features a search bar at the top with 'athena' entered. Below the search bar is a section titled 'YOUR PRODUCTS (1)' for 'athenaClinicals'. This section includes a 'View Progress' button and a 'STATUS' table. Below this is a table with search filters and a list of products.

Use Search Filters Below		PRODUCT	VERSION	PRACTICE TYPE	CLASSIFICATION	CERTIFICATION EDITION	VENDOR	CHPL PRODUCT NUMBER
CERTIFICATION EDITION								
2014	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	athenaClinicals	14.10	Ambulatory	Complete EHR	2014	athenahealth, Inc 140056R06

Figure 38 - CHPL site verification of CEHRT: Choose product

Your Progress

Your product(s) meet 100% of the minimum required Base EHR criteria, CQM domains, and either inpatient or ambulatory CQMs. You can now obtain your CMS EHR Certification ID.

* Additional certification criteria may need to be added in order to meet submission requirements for Medicaid and Medicare programs.

athenaClinicals
14.10
CHPL ID: 140056R06
[Remove Product](#)



Figure 39 - CHPL site verification of CEHRT: Review specs to worksheet submission

YOUR CMS EHR CERTIFICATION ID

1314E01PBWZEAR

Submit this as part of the attestation process for the CMS EHR Incentive Programs. You can email it to yourself or print it for your records.

* Additional certification criteria may need to be added in order to meet submission requirements for Medicaid and Medicare programs.

[Email](#) [Print](#) [Close](#)

Figure 40 - CHPL site verification of CEHRT: Verify CMS EHR Certification ID

EMAIL YOUR CMS EHR CERTIFICATION ID

1314E01PBWZEAR

Enter up to 3 email addresses (separated by commas) to which you would like to send your CMS EHR Certification ID and product collection.

[Send](#) [Cancel](#)

From: noreply@salesforce.com on behalf of Certified Health IT Product List (CHPL) <onc.certification@hhs.gov> Sent: Wed 11/4/2015 4:28 PM
To: Chubbuck, Patricia
Cc:
Subject: Your certification cart

The CMS EHR Certification ID shown corresponds to the collection of products listed below. Submit this ID as part of the attestation process for the CMS EHR Incentive Programs. * Additional certification criteria may need to be added in order to meet submission requirements for Medicaid and Medicare programs.

1314E01PBWZEAR

Certifying Body	Original Practice Type	ONC Certification #	Vendor	Product Name	Product Version #	Product Classification	Certification Edition	Additional Software Required
ICSA Labs	Ambulatory	140056R06	athenahealth, Inc	athenaClinicals	14.10	Complete EHR	2014	athenaCommunicator, Surescripts, FirstDataBank FDB MedKnowledge, Healthwise Patient Instructions

Figure 41 - CHPL site verification of CEHRT: save email from CHPL site in providers' folder

- HIT specialist will review the submitted Patient volume calculation
 - Review that all information has been entered into the worksheet
 - Confirm the start and end dates are appropriate for the program year

The 90 day period I have selected for the Medicaid Eligibility Calculation is: Start Date: **4/1/2015** End Date: **6/29/2015**

Figure 42 - 90 day period for Medicaid Eligibility calculation

- Confirm that the correct calculation has been entered – Medicaid or Needy

Medicaid Eligibility Calculation - NON FQHC/RHC Providers Individual or Practice/Group Level		
Insert the total for Medicaid and Patient encounters; percentage will auto calculate (see guide for details)		
	Medicaid Encounters	200
	Total Patient Encounters	348
	Total Percentage Medicaid Patient Encounters	57%

Figure 43 - Medicaid calculation

- Confirm the Needy calculation is submitted only by an FQHC or RHC

Medicaid Eligibility Calculation - FQHC/RHC Needy Calculation			
All providers at an FQHC/RHC must meet the definition of "practice predominantly" (see guide for details)			
Insert the total for type of encounters as indicated; percentage will auto calculate			
Primary Insurance Carrier			
None - Uninsured - Sliding Scale:	229		
Regular Medicaid	187		
CHIP Medicaid	5		
Subtotal Medicaid-Needy		421	
Medicare	62		
Other Public Insurance	104		
Other			
Subtotal Public Insurance		166	
Private Insurance	110		
Subtotal Private Insurance		110	
		Total Encounters	697
		Total Percentage "Needy Individuals"	60%

Figure 44 - FQHC/RHC Needy calculation

Section C. Part 3. Maine SLR System

C3a. Entering Data into the SLR

Once the HIT specialist has determined an EP has met the eligibility requirements the submitted information is entered into the SLR.

MEHRIP

Welcome: PATTY [Logout](#) [Jump to Content](#)

Home [Provider Search](#) [Reports](#) [MY Reports](#) [Maintenance](#) [DASHBOARD](#)

Home

WELCOME

Help Text For accessibility

- 'F2' Key - Advanced Search
- 'Ctrl + F2' Key - Advanced Payment Search
- 'F8' Key - View All Providers
- 'F7' Key - View Pending Eligibility
- 'F8' Key - View Requiring action
- 'Ctrl + F8' Key - Post Payment-Audits Requiring Action
- 'F9' Key - View Payment Submission
- 'F10' Key - View Updated Providers
- 'Ctrl + F10' Key - View Paid Providers
- 'F11' Key - View Cancelled Providers
- 'F12' Key - View Pending Audits
- 'Ctrl + F12' Key - Post Payment-Open Audits

To get Tiles for each table, use the 'H' hotkey in your screen reader.

Jump to Content will place you at section / region title descriptions.

VERSION 3.70

REMINDERS:

Date	Event
10/01/2011	CHIP calc 2011 2.28%
01/01/2012	CHIP calc 2012 2.21%
01/01/2013	CHIP calc 2013 0.75%
01/01/2014	CHIP calc 2014 0.66%
08/14/2014	office visit MU numbers
01/01/2015	CHIP calc 2015 0.74%
01/28/2015	Athena Stage 2 specialty registry

Next >

Figure 45 - Maine SLR landing page (test version)

The HIT specialist locates the provider's record via the search page in the SLR. There are several options available for search criteria.

Home [Provider Search](#) [Reports](#) [MY Reports](#) [Maintenance](#) [DASHBOARD](#)

Home > Advanced Search

Enter Advanced Search Criteria

Search Type: [Match items that contain search term\(s\)](#)

AND Status is Equal To:

Provider NPI:

Provider TIN:

REGID:

CCN:

Provider Last Name:

Business Name:

Phone Number:

MIMS Number:

Provider City:

Provider Email:

EHR Cert Num:

Payee NPI:

Payee TIN:

EHR Software Status:

Attestation Status:

Payee Last Name:

Payee Organization:

Payee Phone:

Payee City:

Payee Email:

Basic Info Status:

Encounter Status:

Audit Status:

Has Payments:

Is Hospital:

Search on Year(s):

Search on TAG:

[Back](#) [Clear All](#) [Search](#)

Figure 46 - Maine SLR search page

Search result for provider record

Actv?	Result	APY	NPI	CCN	EPEN	Provider	Provider City	Payee	Event Ck	Event Not	Basic Info Ck	Encounter Ck	Ehr Ck	Alu Attest Ck	Auth Ck
<input checked="" type="checkbox"/>	1212121212	1	1212121212	-		Debbie Eggplant	August	012 Family Practice			11111111	-	-	-	-

Figure 47 - Maine SLR: provider quick summary page

C3a1. Provider & Basic Information Check

To begin entering the providers submitted information the HIT specialist selects the Provider & Basic Information button

Home > Provider Details

Payment Year: [dropdown]

UAT/TEST-Development Version
SYSTEM_SETUP - ACTIVE_SYSTEM = UAT
HT19V380U01

CMS/National Provider Information:
 Registration ID: 1212121212
 NPI: 1212121212
 TIN: 001221212 - 55N
 CCN: -
 Provider Name: Debbie Eggplant
 Legal / Business Name: -
 Address: [redacted]
 Email: gregory.lang@maine.gov
 Program Option: MEDICAID
 Provider Type: MD - Physician

Assigned Payee:
 Payee NPI: [redacted]
 Payee TIN: [redacted]
 Payee Name: [redacted]
 Payee Address: [redacted]

Eligibility Information:
 Is Hospital: N
 Entry Date: 09/28/2015
 Application Received: 11/04/2015
 Basic Info Ck: Y - 11/04/2015
 Encounter Ck: Y - 11/05/2015
 Ehr Software Ck: Y - 11/05/2015
 Alu Attest Ck: -
 Eligibility Status: ELIGIBLE - 11/04/2015

Provider Specialties:
 No Provider Specialty specified (PECO9-Taxonomy)

Navigation buttons: Provider & Basic Information (circled), Eligibility & Encounters, EHR SW, Attestation, Payments, External Elements, Subgroups, Chk Payee, Alternate Email Address, Manage Tags, MUWizard EMAIL, summary, Back.

Figure 48 - Maine SLR: provider page

Note the hard coded data received from the NLR. The HIT specialist enters data from the worksheet in the spaces provided that allow for input of data

Provider Information

REGID: 1212121212
 NPI: 1212121212
 TIN: 001221212
 CCN: -
 Provider Name: Debbie Eggplant
 Legal / Business Name: -

Application Sent: 09/28/2015
 Application Received: 11/04/2015

MIHMS Provider Number: 1111111111
 MIHMS Group Number: [input field]
 MIHMS Location Code: [input field]

Is this Provider a Hospital? No
 Participates in HIE / HIN: Yes

Summary Comment: [input field]

Navigation buttons: << Back, NEXT/Save >>

Figure 49 - Maine SLR: provider page: Provider and Basic Information Check

C3a1a. Additional Work Site

If a provider has indicated they work at additional practice sites outside of one organization that that additional site information is entered

Home Provider Search Reports MY Reports! Maintenance DASHBOARD

Home > Provider Details > Edit Provider Details > Work Locations > Edit or Insert Work Locations

Edit PROVIDER_WORK_LOCATIONS

Regid 1212121212
Npi 1111111111
Tin 1111111111
Ccn
Tintype EIN
Business Name ABC Family Practice
Business Address 456 Medical Drive
Business Address2
Business Address City Augusta
Business Address State Maine
Business Address Zip 04333
Business Address Zip4

Work Location Comments
provider works part time ~ 1 day per week at this additional site
The CEHRT at this site is: xxxxxxxxx

Summary of additional work site information

Edit	Npi	Tin	Business Address	Business Address2	Business Address City	Business Address State	Business Address Zip	Business Address Zip4	Business Name
Edit	1111111111	1111111111	456 Medical Drive		Augusta	ME	04333		ABC Family Practice

<< Back Next >> Insert New Work Location

Figure 50 - Maine SLR: provider page: Provider and Basic Information Check: Additional Work location – one additional site added

C3a1b. License Status

The HIT specialist verifies the provider’s license status (see Figure 29: Maine MHIMS system and Figure 30: Verification of provider license status) then selects Yes or No to answer: Provider is licensed with no sanctions?

Home > Provider Details > Edit Provider Details > Work Locations > State Rejection/Exclusion Codes

License/Sanction Status

Provider is LICENSED with NO Sanctions?

State and Federal Exclusion codes

State Rejection Codes

This Provider has No State Rejections or Exclusions

Federal Exclusion Codes

This Provider has No Federal Exclusions

<< Back Next >>

Figure 51 - Maine SLR: provider page: Provider and Basic Information Check: License Status

C3a1c. Payee Information

The HIT specialist enters the payee information submitted on the worksheet and verifies the NLR data matches the worksheet submission. This information is also verified in the MIHMS data base (see Figure xx: Maine MHIMS system). If any data is requires clarification the provider is contacted.

Home | Provider Search | Reports | MY Reports | Maintenance | DASHBOARD

Home > Provider Details > Edit Provider Details > Work Locations > State Rejection/Exclusion Codes > Edit Payee Details

The Registered Provider (NPITIN) has ASSIGNED their EHR Incentive Payment to a Third-Party (PAYEE NPITIN). Please verify the NPITIN and enter the Name, Address and Contact information where an Incentive Payment should be disbursed.

Provider Details

Registered NPI 1212121212
 Registered TIN 001221212
 Assigned Payee NPI [redacted] >> Derived AdvME Vendor Code VCC [redacted]
 Assigned Payee TIN [redacted] EIN [redacted]

AdvME Vendorcode: VC [redacted]
 ✓ Payee Vendor - OK
 All Vendor - Details

Update Payee Basic Information

CMS - Payee First Name [redacted] Middle [redacted] Last [redacted] Suffix [redacted]

CMS - Payee Organization Name XYZ Family Practice

Payee Address 123 Hospital Lane

Payee Address2 [redacted]

Payee City Augusta State Maine

Zip 04333 Zip+4 [redacted]

Payee Phone 207-111-1111 Extension [redacted]

Payee Email xyz@maine.org

<< Back Next >>

Figure 52 - Maine SLR: provider page: Provider and Basic Information Check: Payee Information

C3a1d. Completion of Provider and Basic Information Check

The HIT specialist selects one of the options available to record the basic information check in the SLR (verification in MIHMS, unique provider registration in NLR, active and unsanctioned license status, verification of payee information):

- Pending: Provider has not submitted all required information or there are updates pending from the NLR.
- Yes: Provider’s application meets the basic information check
- No: If all options for a provider to meet the basic information check have been exhausted

the HIT specialist will select no. This will mark the provider as ineligible for the program year.

Figure 53 - Maine SLR: provider page: Provider and Basic Information Check: Basic Information Check status

At the time a provider is marked as meeting the basic information check an automated B7 confirmation notice is sent from the SLR to the NLR.

C3b. Eligibility & Encounters

The HIT specialist enters the submitted Medicaid eligibility encounter data from the worksheet into the SLR by selecting the Eligibility & Encounters tab

Figure 54 - Maine SLR: provider page: Eligibility & Encounters

The HIT specialist enters the information as submitted on the Medicaid eligibility worksheet.

- Did the provider perform 90% of their services in an Inpatient Hospital or ER Hospital setting?
 - Selection of yes/no
- Does the EP practice in an FQHC/RHC?
 - Yes – when yes is selected the following areas open for data input
 - FQHC/RHC NPI – worksheet data must match the hard coded data from NLR, as well as cross referenced to MIHMS system
 - FQHC/RHC EIN– worksheet data must match the hard coded data from NLR, as well as cross referenced to MIHMS system
 - No – if a provider does not work at an FQHC no is selected.
- Start date for providers 90 day period for the eligibility calculation, the SLR automatically calculates the end date
- For providers that submitted a Medicaid based eligibility calculation the numerator is placed in the Medicaid Encounter box
- For providers that submitted a Needy based eligibility calculation the numerator is placed in the Needy Encounter box (Needy based used for sample)

- The total patient encounter (denominator) is entered
- The SLR calculates the Medicaid Encounter percent based on the data inserted
- A free text area is available for any documentation needed

Home > Provider Details > Non-Hospital Workflow(Medicaid)

Provider and Payee Information

Provider Name: Eggplant, Debbie Payee Name: XYZ Family Practic Is a Hospital: N
 Provider NPI: 1212121212 Payee NPI: [REDACTED] Program Option: MEDICAID
 Provider TIN: 001221212 - SSN Payee TIN: [REDACTED] EIN
 Provider Type: MD

MEDICAID Provider Eligibility & Encounters (Non-Hospital)

Did the Provider perform 90% of their services in an inpatient Hospital or ER Hospital setting? (Research & Verify the Provider's Place of Service 21 & 23) --

Is this EP a Pediatrician?

Does the EP practice in a FQHC or RHC?

FQHC/RHC NPI

FQHC/RHC TIN

FQHC/RHC TIN TYPE

Starting Date(MM/DD/YYYY):

Ending Date

Total CHIP Encounters for this Period

Total MEDICAID Encounters for this Period

Total NEEDY Encounters for this Period

Enter TOTAL PATIENT Encounters for this Period

Pct Medicaid Encounters

Encounter Comments

Figure 55: Maine SLR: provider page: Eligibility & Encounters: Provider submitted data entered

C3b1. Eligibility Determination

The HIT specialist selects one of the options available to record eligibility status in the

- Pending: If a provider has not met all requirements the HIT specialist will select pending; then review with the provider any information required to meet eligibility.
- Yes: Provider’s application meets practice eligibility criteria as well as meet or exceed encounter thresholds
- No: If all options for a provider to meet eligibility have been exhausted the HIT specialist will select no. This will mark the provider as ineligible for the program year.

Home Provider Search Reports MY Reports! Maintenance DASHboard

Home > Provider Details > Non-Hospital Workflow(Medicaid) > Eligibility Check

CHECKPOINT - Encounter Volumes & Provider Practice Details

Does the Provider meet Practice Eligibility Criteria, as well as, Meet or Exceed Encounter Thresholds? (If you are unsure of their practice eligibility and/or still collecting encounter details - choose "Pending")

Figure 56 - Maine SLR: provider page: Eligibility & Encounters: Eligibility determination

C3b2.CEHRT Information

To enter the CEHRT information submitted by the provider, the HIT specialist selects the EHR SW button



Figure 57 - Maine SLR: provider page: EHR SW

C3b2a.CEHRT Selection and Input

The HIT specialist assigns the providers product from a listing of products used by Maine providers. This information populates the SLR and is available in reports reflecting the vendors and products used in Maine.

The product name, vendor, version, CHPL and CERT ID number are then entered. If the CEHRT ID was not updated on the NLR by the provider the HIT specialist enters the CEHRT ID number in the SLR box to record the version used for the submitted program year. This information will update the NLR.

Home > Provider Details > EHR SW

Assigned Provider Products

Product Code	Product Name	Description	CHPL#	Version	System Type	Vendor Code	Del
1314E01QEXWMEAX	-	AthenaClinicals_1314E01QEXWMEAX	-	14.1	-	athenaHealth	🗑️

[Assign Provider's PRODUCT](#)

EHR SW Details

ATTEST AIU TYPE or MU:

EHR Product Name:

EHR SW Vendor:

EHR SW Version #:

EHR CHPL Num:

EHR Comment:

State (SLR) EHR Certnum (if NLR# below is Blank):

NLR Registered EHR CERTNUM: 1314E01PE0AWEAR
ONC Certification Year: Compliant to 2014

[<< Back](#) [Next >>](#)

Figure 58 - Maine SLR: provider page: EHR SW- CEHRT assignment

C3b2b. CEHRT Validation

The HIT specialist enters yes the provider is using an EHR system on the ONC's list of Certified

Systems.

Home > Provider Details > EHR SW > EHR Check

CHECKPOINT - EHR Software System Certification

Is the Provider using an EHR System on the ONC's list of Certified Systems? Pending

(If you are verifying the system or awaiting a response - choose "Pending")

<< Back Next >>

-Select-
Pending
Yes
No

Figure 59 - Maine SLR: provider page: EHR SW – CEHRT validation

C3b3. External Elements

The HIT specialist selects External Elements to enter information that affect the providers audit risk score

Provider & Basic Information Eligibility & Encounters EHR SW Attestation

Payments External Elements Subgroups Chk Payee Alternate Email Address

Figure 60 - Maine SLR: provider page: External Elements

C3b3a. Risk Factors

1. Verification of Medicaid provider status and date provider joined MaineCare

Enter the date when the provider joined or registered for Medicaid

**Is there Data Available or
Expected?**

Enter a DATE



2. Information is entered if a provider was ever terminated from the MaineCare program. A provider would not be eligible for the Incentive program if terminated from MaineCare.

If the provider was terminated from the MaineCare program enter the DATE when the Provider was terminated along with the REASON for termination.

**Is there Data Available or
Expected?**

Enter a DATE



Enter the Requested TEXT

3. If a provider changes any of the data listed post payment that would affect the eligibility for that program year the information is added here and the audit division is notified by the HIT specialist. The SLR is notified of any updates via a B6 from the NLR. This section is entered post payment if applicable.

Enter Yes if the Provider's registration, eligibility, software, etc. required modification POST Payment. Enter a date when this change was effected and any text describing what was changed

**Is there Data Available or
Expected?**

Enter a DATE



Enter YES or NO

Enter the Requested TEXT

4. Information supplied by the provider for multiple practice sites is entered here. An additional practice site is one that is separate from a single organization with a different

CEHRT system not directly connected. The provider that works at multiple practice sites with separate CEHRT products must combine the MU reports from all sites and submit the combined data for their MU reporting period. This section alerts the SLR we should expect the MU report to be comprised of multiple systems.

Simple YES/NO Indicator that the Provider works at more than one Practice. [MULTP]

Is there Data Available or Expected?

Enter YES or NO

The information for the external elements is saved in the SLR.

Figure 61 - Maine SLR: provider page: External Elements

C3c. Maintenance (SLR) Organization Level and Provider Site Location

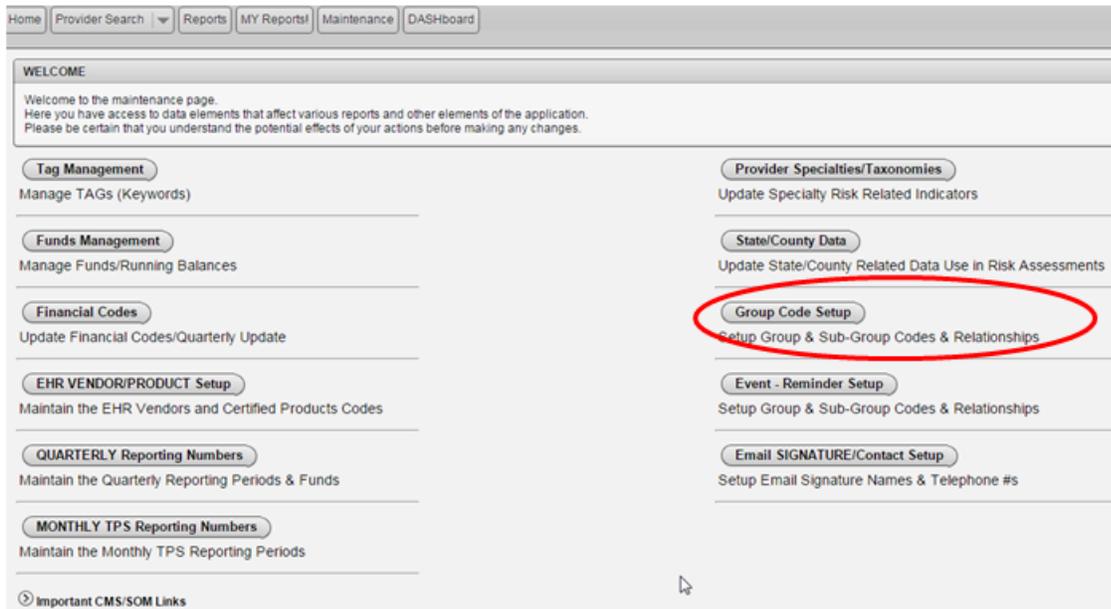
The HIT specialist enters the organization structure and practice location for each provider. This aids in the outreach effort of the program as well as a determination of where CEHRT is in use across the state.

The Maintenance button gives access to the HIT specialist to enter the group code set up for each organization and practice location



Figure 62 - Maintenance (SLR)

The HIT specialist selects the Group Code setup to enter the organization and practice structure



HIT specialist sets up the parent organization (SLR)



Figure 63 - Maintenance (SLR) data element selection: Group Code Setup

HIT specialist sets up the practice location within the parent organization. Once this is entered into the SLR the HIT specialist can assign this practice location to any provider associated.

EDIT the Practice SUB.GROUP data for **XYZ_FAMILY_PRACTICE** under Parent GROUP **XYZ_HEALTH_CARE** .

Enter a Name/Description: XYZ Family Practice

Enter the SIZE of the Practice: 5

Enter the NAME of the Practice: XYZ Family Practice

Enter JUST the Street or Building NUMBER ONLY: 123

Enter the Practices STREET NAME: Hospital

Enter the TYPE of Street or Roadway: Lane

Enter OTHER address details (Suite, Floor, Annex, etc.):

Enter the CITY/TOWN where the Practice is located: Augusta

Enter the STATE where the Practice is located: Maine

Enter the 5-DIGIT ZIP CODE for the Practice: 04333

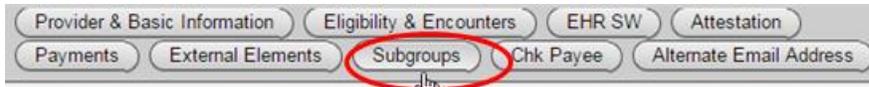
(4-Digit Extension):

Enter the Contact PHONE # for this Practice: 111-111-1111

Enter the Contact EMAIL for this Practice: xyz@maine.org

<< BACK << SAVE

HIT specialist returns to the provider record and selects the Subgroup button



HIT specialist locates the practice site and verifies the parent organization and information submitted on the Medicaid eligibility worksheet

WWC2	Site 2	WWC
XYZ FAMILY PRACTICE	XYZ Family Practice	XYZ_HEALTH_CARE

HIT specialist selects the practice site and the provider is then associated to that site. If a provider has multiple practice sites they can be added.

REGID	1212121212
Address	[REDACTED]
Provider	Debbie Eggplant
Legal Name	-
Email	gregory.tang@maine.gov
Provider Type	MD - Physician
Entry Date	09/28/2015

NPI	1212121212
TIN	001221212 - SSN
CCN	-
Payee TIN	[REDACTED]
Payee NPI	[REDACTED]
Program Option	MEDICAID
Payee name	XYZ Family Practic (asof PY 1)

Provider SUBGROUPS

These are the Provider's Local Practice Group (SUBGROUP)
 Click on a SUBGROUP to UNASSIGN that associated Subgroup.
 NOTE: You cannot remove a PRIMARY sub-group if there are more than one Sub-Group Assigned.

Subgroup Code	Description	Group Code	Primary	
XYZ_FAMILY_PRACTICE	XYZ Family Practice	XYZ_HEALTH_CARE	Y	Set as Primary

Figure 64 - Subgroups – provider practice location

The workflow process for AIU application and MU submission differ at this point. A provider that is submitting MU proceeds with the MU submission; the provider applying for AIU goes to the attestation statement. The attestation statement will be sent to the provider submitting MU after the MU has been submitted and accepted. All steps listed prior to and after the MU submission are the same for either an AIU or MU submission.

C3d. Submission of Meaningful Use to the SLR

The process for a provider to submit meaningful use is set up as follows:

- Providers in program years beyond year 1 will contact the Maine HIT program via email or phone and request that their status be moved to the next program year in the SLR.
- The HIT specialist moves the provider to the next program year in the SLR by selecting “Create a New Payment Year for this provider”

CMS/National Provider Information:	Assigned Payee	Eligibility Information
Registration ID: 1000034967	Payee NPI: 1659392819	Is Hospital: N
NPI: 1811954566	Payee TIN: 010179500 - EIN	Entry Date: 11/18/2011
TIN: 281428369 - SSN	Payee Name: WEBBER HOSPITAL ASSOCIATION	Application Received: 12/15/2011
CCN: --	Payee Address: Po Box 626, BIDDEFORD, ME 04805	Basic Info Ok: Y - 12/27/2011
Provider Name: Gregory A Van Gundy		Encounter Ok: Y - 12/27/2011
Legal / Business Name: --		Ehr Software Ok: Y - 12/16/2011
Address: 9 Healthcare Drive, Suite 101, Biddeford, ME 04805-5407		Aliu Attest Ok: Y - 12/28/2011
Email: gregory.tang@maine.gov		Eligibility Status: ELIGIBLE - 12/27/2011
Program Option: MEDICAID		
Provider Type: MD - Physician		

Provider Specialties:
Provider Specialty: 16 - Obstetrics/Gynecology

ALERT: This Payment Year (#1) has been CLOSED and PAYMENTS have been DISBURSED

Create a New Payment Year for This Provider

Figure 65 - SLR screen shot for moving a provider to a new program year

- The creation of a new payment year automates the SLR to send the provider an email specific to the program year for that provider (year 1, 2, etc.) with the Medicaid Eligibility Worksheet attached



(UAT TEST)Action Required if you want t

Figure 66 - Provider email from SLR after provider is rolled to the next program year with attached worksheet³⁷

- The submission and approval of the Medicaid Eligibility worksheet is as described previously.
- The HIT specialist will enter program year, stage and iteration of stage

MU Definition/Stage Expectations

Enter the MU Definition Year (Rule Adoption) for this provider: -Select-

Enter MU STAGE #: -Select-

Enter MU Reporting Period (90/365): -Select-

Enter # of times this STAGE is (re)submitted: -Select-

Figure 67 - MU submission: Determining and setting the MU expectations

MU Definition/Stage Expectations

Enter the MU Definition Year (Rule Adoption) for this provider: 2014

Enter MU STAGE #: 1

Enter MU Reporting Period (90/365): 90 Days (~3 Months)

Enter # of times this STAGE is (re)submitted: 1 - FIRST Time submitting THIS Stage

Figure 68- MU submission: specific data entered for a provider

- The SLR sends a B7 response to the NLR of EP eligibility
- The HIT specialist generates a “wizard” application email to the EP from the SLR



FW (UAT TEST)Action Required

³⁷ Document is embedded.

Figure 69 - MU submission: Maine MU Wizard email (please click on email to see the document a provider receives)³⁸

- The Maine MU wizard email contains a link in the body for the provider to download the OIT-designed application for the collection of MU data
- The [Maine MU wizard guide](#) is attached to the email to assist the provider with the input of their MU data
- The email states what program year the provider is in and what MU definition, year and stage they are due to submit. This is based on the selection the HIT specialist has set in the SLR from the information supplied by the provider on the Medicaid Eligibility worksheet and the provider history in the SLR. (See figure above)

C3d1. Provider Meaningful Use Requirements 2012 through 2014

C3d1a. EP Stage 1 Meaningful Use Measures required of Eligible Professionals for program year 2012:

- 15 required core objectives
- 5 out of 10 menu measures
- 6 - 9 CQM's: 3 required core measures (or 3 alternate core measures) and 3 additional measures (selected from a set of 44 clinical quality measures).

C3d1b. EP Stage 1 Meaningful Use Measures required of Eligible Professionals for program year 2013:

- 14 required core objectives
- 5 out of 10 menu measures
- 6 - 9 CQM's: 3 required core measures (or 3 alternate core measures) and 3 additional measures (selected from a set of 44 clinical quality measures)

C3d1c. EP Stage 1 Meaningful Use Measures required of Eligible Professionals for program year 2014:

- 13 required core objectives
- 5 out of 9 menu measures; at least 1 public health measure must be selected
- 9 CQM's covering at least 3 domains (selected from a set of 64 clinical quality measures)
- [Provider CQM measures 2014 definition](#)

C3d1d. EP Stage 2 Meaningful Use Measures required of Eligible Professionals for program year 2014:

- 17 required core objectives
- 3 out of 6 menu objectives
- 9 CQM's covering at least 3 domains (selected from a set of 64 clinical quality measures)

³⁸ Document is embedded.

- [Provider CQM measures 2014 definition](#)

C3d1e. EP Modified Stage 2 Meaningful Use Measures required of Eligible Professionals for program year 2015-2017:

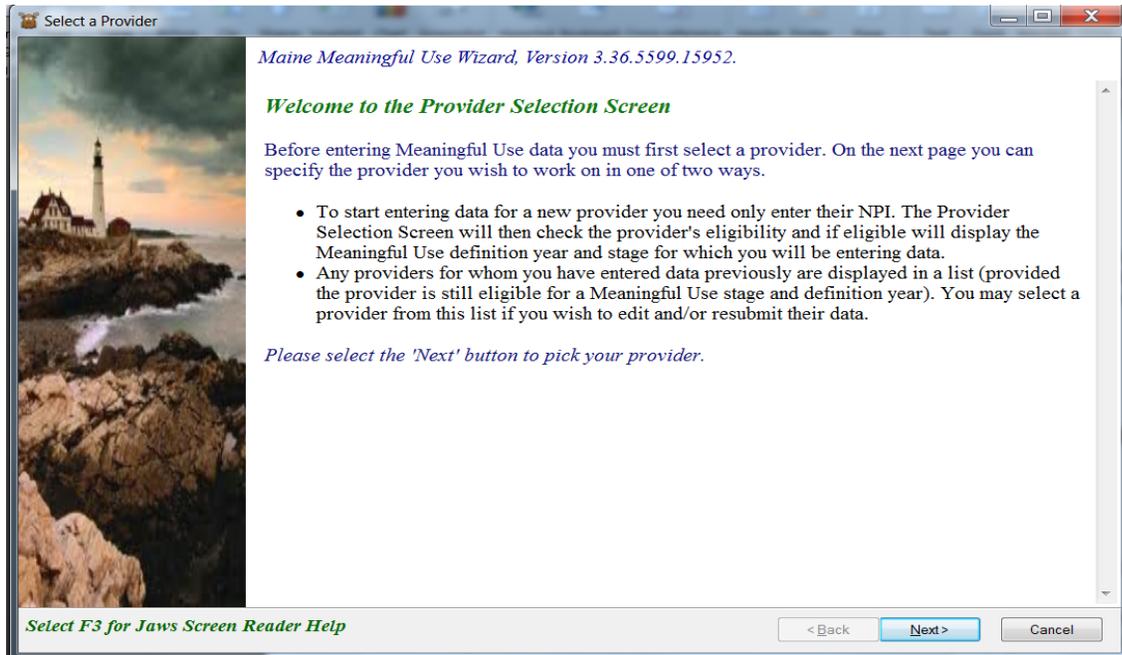
- 9 required core objectives
- 1 Public Health Objective
- 9 CQM's covering at least 3 domains (selected from a set of 64 clinical quality measures)
- [Provider CQM measures 2014 definition](#)

C3d2. SLR Screens for Meaningful Use Stage 2

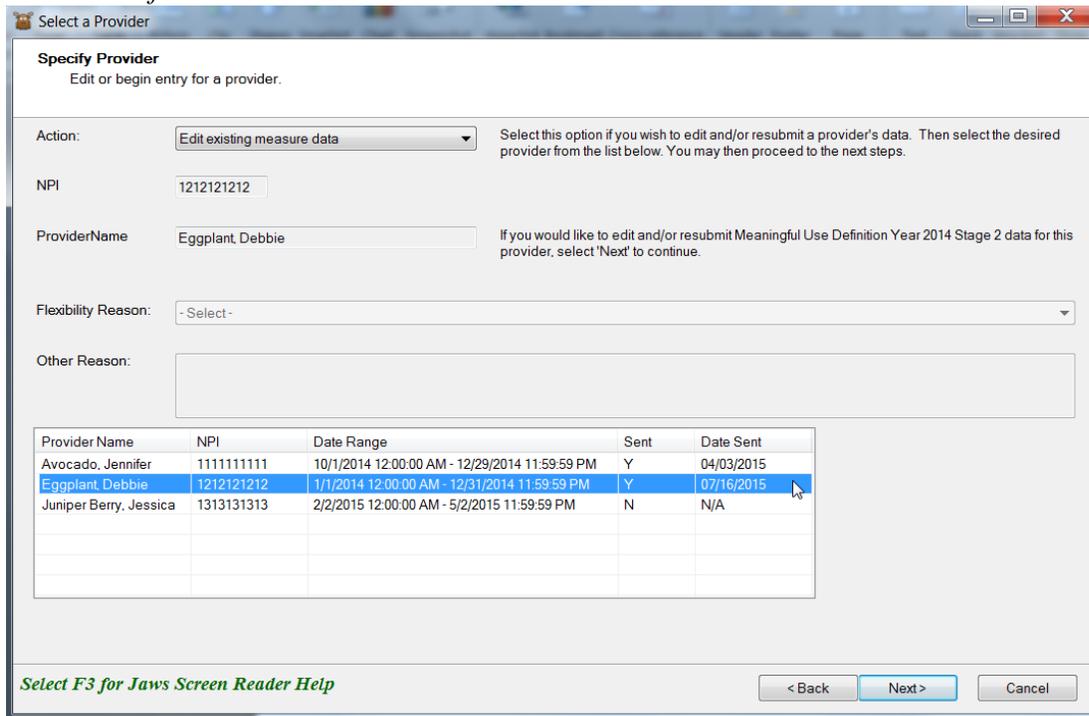
For demonstration of how Maine collects meaningful use data we are presenting a Stage 2 test case for program year 2014. The test case for stage 2 was set up with a 365 day reporting period although the reporting period for all providers in 2014 was 90 days. The wizard application presents the screens appropriate to the stage and MU definition set. For this SMHP we will show all screens available to a provider for the 2014 MU definition of Stage 2. This is for demonstration purposes only. For detailed business policy and processes please review Appendix C on starting on page 292.³⁹

³⁹ Hyperlinked Cross-reference

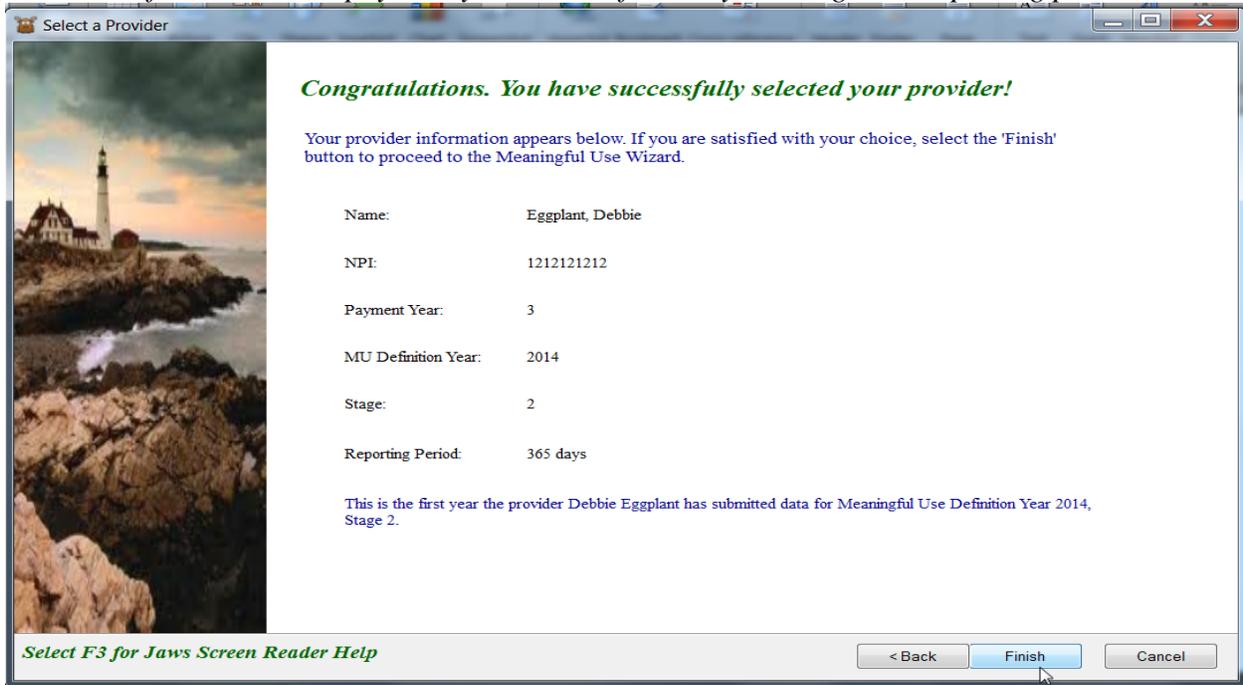
Welcome Screen



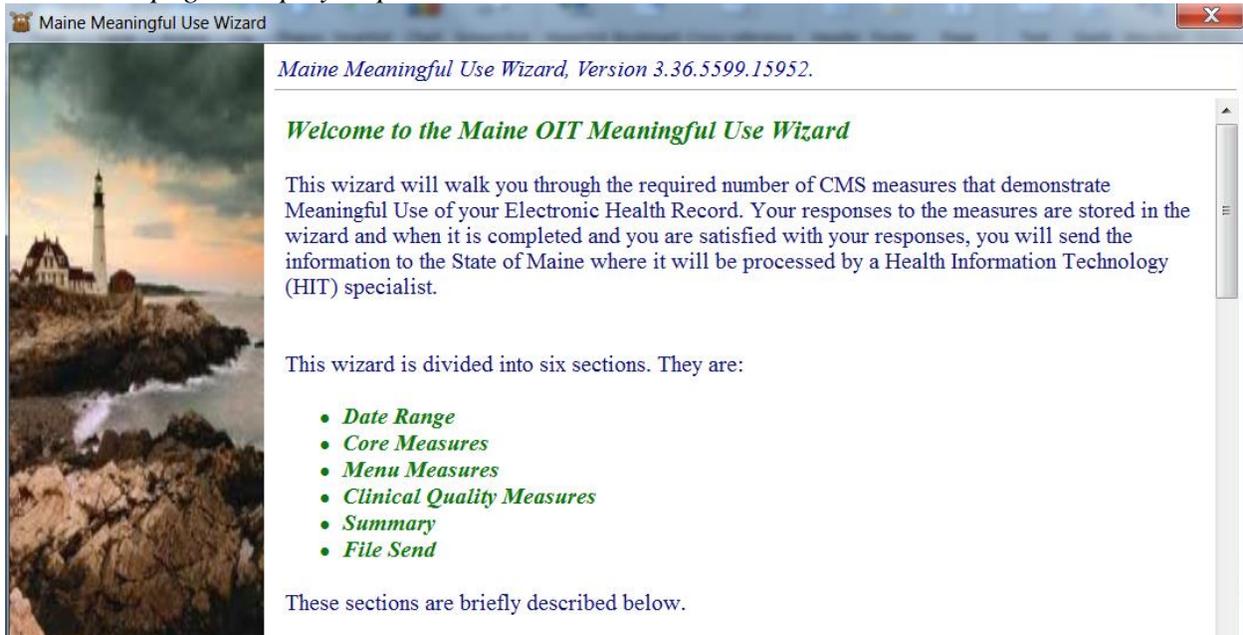
Provider information



Provider information with payment year, MU definition year, stage and reporting period



Instruction page – step by step instructions



Date Range

In this section you enter the date range used for your Meaningful Use data. Example: for a 90 day period the providers met MU for January 1, 2014 through March 31, 2014 you will enter the start date of January 1, 2014 and the wizard will calculate the end date of March 31, 2014 for you. Note that the reporting period for 2014 is 90 days for all MU submissions.

Core Measures

In this section you will enter your data for the Core Measures. One Wizard page is devoted to each core measure. Each Wizard page has a help link to the CMS document (specification sheet) pertaining to that measure. This link is located in the upper right hand corner of each page.

Menu Measures

In this section you will enter your data for the Menu Measures. One Wizard page is devoted to each measure. Each Wizard page has a help link to the CMS document (specification sheet) pertaining to that measure. This link is located in the upper right hand corner of each page.

Clinical Quality Measures (CQM)

In this section you will enter your data for the Core, Alternative and Additional CQMs. Further instructions for choosing your CQMs are provided. One Wizard page is devoted to each measure. Each Wizard page has a help link to the CMS document (specification sheet) pertaining to that measure. This link is located in the upper right hand corner of each page.

Summary

In this section you will be presented with a summary of your Core Measure entries, Menu Measure entries and CQM entries. One page of summary information is supplied for each of the three categories. Summaries may be saved to a file, printed or displayed in a browser.

File Send

On the last page of the wizard you will send your completed information to the State of Maine, or you may save the information and send it at a later time. The listing of each providers send status is at the start of the wizard.

Note:

- *The Meaningful Use Wizard saves your entries as you proceed; if you do not complete the Wizard in one sitting you will not lose any information that has been entered.*
- *For core and menu measures, ALL exclusion fields must be set to a valid value (either 'Yes' or 'No') before you can proceed to the next measure.*

Your Responsibilities

- *EPs are responsible for maintaining adequate documentation to substantiate any responses given for any and all Meaningful Use Measures.*

Links:

[Maine HIT/EHR Page](#)

[EHR Incentive Program Overview](#)

[Meaningful Use Overview](#)

[Certified EHR Technology](#)

[EHR FAQ](#)

Provider information screen - this information is generated from the SLR at the time the HIT specialist enters the provider's eligibility data and the stage and iteration of MU for this program year. The provider is responsible for verifying the data is correct.

Maine Meaningful Use Wizard

Enter Date Range
Enter the date range for measure data.
Provider: Eggplant, Debbie (NPI: 1212121212)

Provider Information

Provider Name: Eggplant, Debbie
Provider NPI: 1212121212
Payment Year: 3
MU Definition Year: 2014
Stage: 2
Reporting Period: 365 days

This is the first year the provider Debbie Eggplant has submitted data for Meaningful Use Definition Year 2014, Stage 2.

Date Range for Data *(MU Definition Year 2014, Stage 2, MU (year 1) 365 day reporting beginning on the 1st of January)*

Start Date: Wednesday, January 01, 2014
End Date: Wednesday, December 31, 2014

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C3d2a. Stage 2 MU Core Measures

Maine Meaningful Use Wizard

Core Measures [Core Measure Overview](#)

Core Measures Section

Provider: Egplant, Debbie (NPI: 1212121212)

Section 1: Core Measures.

Seventeen out of Seventeen Core Meaningful Use Measures must be met according to the CMS threshold.

- Exception – If CMS allows exclusion to a measure and the EP attests to that exclusion then that measure is still considered completed.
- Note: Core #16 measure can be met by registering your intent to submit ongoing data submission on the Maine CDC registration site. Please click the link below to download the CDC registration wizard.
[Download the CDC Registration Wizard.](#)

Using the CDC Registration Wizard you can register for all available public health registries at one time. Please follow the directions in the wizard to complete your registrations. Retain the acknowledgement email you receive as documentation that you have registered.

After registering you will be able to meet Core measure #16, menu measures #1 #5 with the registration. You do not need to exclude from those measures if you complete the registration. Please see the individual measure specification sheet for details.

For more information on Meaningful Use measures involving the CDC Health Registries please refer to the document linked below:
[Entering Meaningful Use information for measures relating to the Maine CDC Health Registries.](#)

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C3d2a1. Resources for Providers

- The upper right corner of the page has a link to download a document for Stage 2 (2014 MU submissions): [Stage 2 Overview Tip sheet](#)
- Maine developed a wizard application for providers to register for the Public Health registries. This page contains a link to download that application as well as a guide to the PH registry process (2014 MU submissions)
 - [Download the CDC Registration Wizard](#)
 - [Entering Meaningful Use Information for measures relating to the Maine CDC Health Registries](#)

C3d2a2. Stage 2 Core Measures

The provider enters their MU data as it is reported by their CEHRT.

Resources for Providers: Each page of the wizard application contains resources for providers particular to the measure

- The CMS specification sheet is available for each measure by clicking the link in the upper right corner.
[CMS Specification Sheet for this measure](#)
- Each objective includes a description of all measures in the objective as well as any exclusion available.

- Some measures have generated repeat questions from providers. We have entered additional information by adding a clickable link that pops up a message related to a topic associated with that objective

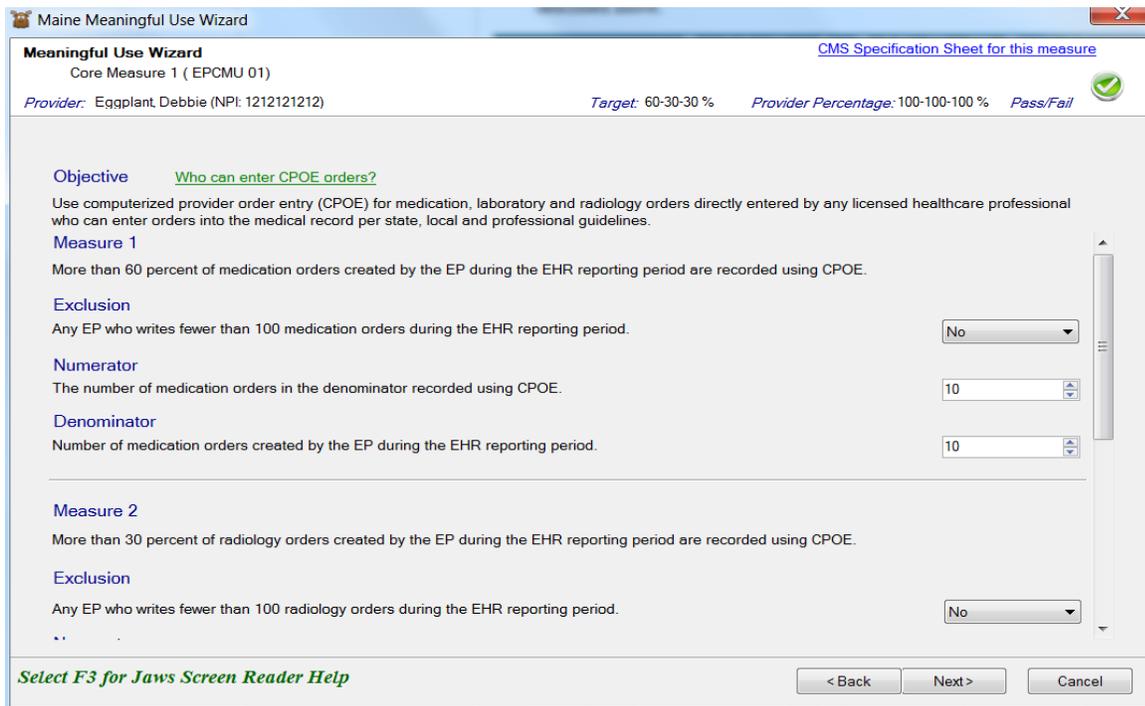
[Who can enter CPOE orders?](#)

Licensed healthcare professionals including Medical assistants who are credentialed, certified, licensed, or otherwise affirmed as medical assistants by an organization other than the one which employs them can enter orders for the purpose of this objective.

- The target percent required for the measure is listed as well as the percent the provider has met as they enter data. The Pass/Fail notice is a green circle with a checkmark when the provider has entered all required data

Target: 60-30-30 % Provider Percentage: 100-100-100 % Pass/Fail 

Core measure #1: Correctly and fully completed – provider can click the next button to move to the next measure



Meaningful Use Wizard
Core Measure 1 (EPCMU 01)
Provider: Eggplant, Debbie (NPI: 1212121212) Target: 60-30-30 % Provider Percentage: 100-100-100 % Pass/Fail 

Objective [Who can enter CPOE orders?](#)
Use computerized provider order entry (CPOE) for medication, laboratory and radiology orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines.

Measure 1
More than 60 percent of medication orders created by the EP during the EHR reporting period are recorded using CPOE.

Exclusion
Any EP who writes fewer than 100 medication orders during the EHR reporting period. No

Numerator
The number of medication orders in the denominator recorded using CPOE. 10

Denominator
Number of medication orders created by the EP during the EHR reporting period. 10

Measure 2
More than 30 percent of radiology orders created by the EP during the EHR reporting period are recorded using CPOE.

Exclusion
Any EP who writes fewer than 100 radiology orders during the EHR reporting period. No

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- Provider cannot proceed until all required data is entered. The next button is not available to move to the next measure and the Fail notice is visible. The target percent has not been reached with the data entered.

Target: 50 % Provider Percentage: 10 % Pass/Fail 

Core measure #1: Screen showing provider has not completed all areas required and is not able to move beyond the screen until all required information is entered. Note the “Next” tab is greyed out and is not available

Maine Meaningful Use Wizard

Meaningful Use Wizard [CMS Specification Sheet for this measure](#)

Core Measure 1 (EPCMU 01)

Provider: Eggplant, Debbie (NPI: 1212121212) Target: 60-30-30 % Provider Percentage: 0-0-0 % Pass/Fail

Objective [Who can enter CPOE orders?](#)

Use computerized provider order entry (CPOE) for medication, laboratory and radiology orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines.

Numerator
The number of radiology orders in the denominator recorded using CPOE 0

Denominator
Number of radiology orders created by the EP during the EHR reporting period. 0

Measure 3
More than 30 percent of laboratory orders created by the EP during the EHR reporting period are recorded using CPOE.

Exclusion
Any EP who writes fewer than 100 laboratory orders during the EHR reporting period. -Select-

Numerator
The number of laboratory orders in the denominator recorded using CPOE. 0

Denominator
Number of laboratory orders created by the EP during the EHR reporting period. 0

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Core measure 2

Meaningful Use Wizard
Core Measure 2 (EPCMU 02)
Provider: Egplant, Debbie (NPI: 1212121212) Target: 50% Provider Percentage: 100% Pass/Fail

Objective
Generate and transmit permissible prescriptions electronically (eRx).

Measure
More than 50 percent of all permissible prescriptions, or all prescriptions, written by the EP, are queried for a drug formulary and transmitted electronically using CEHRT.

Exclusion 1
Any EP who writes fewer than 100 permissible prescriptions during the EHR reporting period. Does this exclusion apply to you? No

Exclusion 2
Any EP who does not have a pharmacy within their organization and there are no pharmacies that accept electronic prescriptions within 10 miles of the EP's practice location at the start of his/her EHR reporting period. Does this exclusion apply to you? No

Numerator
The number of prescriptions in the denominator generated, queried for a drug formulary and transmitted electronically using CEHRT. 10

Denominator
Number of prescriptions written for drugs requiring a prescription in order to be dispensed other than controlled substances during the EHR reporting period; or Number of prescriptions written for drugs requiring a prescription in order to be dispensed during the EHR reporting period. 10

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- Additional information for providers to be aware of when common denominators should match other measures with the same denominator definition. This is available on all measures with the denominator definition for unique number of patients seen by the EP during the EHR reporting period.

[Denominator](#) [Note on Denominator](#)

Please note: this denominator measures the unique number of patients seen by the EP during the EHR reporting period. This denominator number should match all other measures with the same denominator definition. This definition is common to core measures 3, 4, 7, 13 and 17 as well as menu measures 2 and 4.

Core measure 3:

Meaningful Use Wizard
Core Measure 3 (EPCMU 03)

[CMS Specification Sheet for this measure](#)

Provider: Eggplant, Debbie (NPI: 1212121212) Target: 80 % Provider Percentage: 100 % Pass/Fail 

Objective
Record all of the following demographics:
Preferred Language
Sex
Race
Ethnicity
Date of Birth

Measure
More than 80 percent of all unique patients seen by the EP have demographics recorded as structured data.

Numerator
Number of patients in the denominator who have all the elements of demographics (or a specific exclusion if the patient declined to provide one or more elements or if recording an element is contrary to state law) recorded as structured data.

Denominator [Note on Denominator](#)
Number of unique patients seen by the EP during the EHR reporting period.

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Core measure 4:

Maine Meaningful Use Wizard

Meaningful Use Wizard [CMS Specification Sheet for this measure](#)
Core Measure 4 (EPCMU 04)

Provider: Eqqplant, Debbie (NPI: 1212121212) Target: 80 % Provider Percentage: 100 % Pass/Fail 

Objective
Record and chart changes in the following vital signs: height/length and weight (no age limit); blood pressure (ages 3 and over); calculate and display body mass index (BMI); and plot and display growth charts for patients 0-20 years, including BMI.

- Height
- Weight
- Blood Pressure
- Calculate and display body mass index (BMI)
- Plot and display growth charts for children 2-20 years, including BMI.

Measure
More than 80 percent of all unique patients seen by the EP have blood pressure (for patients age 3 and over only) and/or height and weight (for all ages) recorded as structured data.

Exclusion 1
Any EP who sees no patients 3 years or older is excluded from recording blood pressure. Exclusion from this requirement does not prevent an EP from achieving meaningful use. Does this exclusion apply to you?

Exclusion 2
An EP who believes that all three vital signs of height, weight, and blood pressure have no relevance to scope of practice would be excluded from this requirement. Exclusion from this requirement does not prevent an EP from achieving

Exclusion 3
An EP who believes that height and weight are relevant to their scope of practice, but blood pressure is not, is excluded from recording blood pressure. Exclusion from this requirement does not prevent an EP from achieving meaningful use.

Exclusion 4
An EP who believes that blood pressure is relevant to their scope of practice, but height and weight are not, is excluded from recording height and weight. Exclusion from this requirement does not prevent an EP from achieving meaningful use.

Numerator
Number of patients in the denominator who have at least one entry of their height, weight and blood pressure (ages 3 and over) recorded as structured data.

Denominator [Note on Denominator](#)
Number of unique patients seen by the EP during the EHR reporting period.

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Core measure 5:

Maine Meaningful Use Wizard

Meaningful Use Wizard
Core Measure 5 (EPCMU 05)

[CMS Specification Sheet for this measure](#)

Provider: Eggplant, Debbie (NPI: 1212121212) Target: 80 % Provider Percentage: 100 % Pass/Fail

Objective
Record smoking status for patients 13 years old or older.

Measure
More than 80 percent of all unique patients 13 years old or older seen by the EP have smoking status recorded as structured data.

Exclusion
Any EP that neither sees nor admits any patients 13 years old or older. Does this exclusion apply to you?

Numerator
Number of patients in the denominator with smoking status recorded as structured data.

Denominator
Number of unique patients age 13 years or older seen by the EP during the EHR reporting period.

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For all yes/ no answers there is a pop up to remind provides to maintain documentation for the measure:

<u>Note for Documentation</u>	All yes/no answers require a screen shot of your program having the described capabilities for your records. A date needs to be added to show the required measure requirement was active during the reporting period.
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Core measure 6:

Maine Meaningful Use Wizard

Meaningful Use Wizard [CMS Specification Sheet for this measure](#)

Core Measure 6 (EPCMU 06)

Provider: Eggplant, Debbie (NPI: 1212121212) Pass/Fail 

Objective
Use clinical decision support to improve performance on high-priority health conditions.

Measure 1 [Note for Documentation](#)

Implement five clinical decision support interventions related to four or more clinical quality measures at a relevant point in patient care for the entire EHR reporting period. Absent four clinical quality measures related to an EP's scope of practice or patient population, the clinical decision support interventions must be related to high-priority health conditions. Yes ▾

Measure 2 [Note for Documentation](#)

The EP has enabled and implemented the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period. Yes ▾

Exclusion

Any EP who writes fewer than 100 medication orders during the EHR reporting period. Do you qualify for this exclusion? No ▾

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Core measure 7:

Maine Meaningful Use Wizard

Meaningful Use Wizard [CMS Specification Sheet for this measure](#)
Core Measure 7 (EPCMU 07)

Provider: Eggplant, Debbie (NPI: 1212121212) Target: 50-5 % Provider Percentage: 100-100 % Pass/Fail 

Objective
Provide patients the ability to view online, download and transmit their health information within four business days of the information being available to the EP.

Measure 1
More than 50 percent of all unique patients seen by the EP during the EHR reporting period are provided timely (available to the patient within 4 business days after the information is available to the EP) online access to their health information.

Numerator
The number of patients in the denominator who have timely (within 4 business days after the information is available)

Denominator [Note on Denominator](#)
Number of unique patients seen by the EP during the EHR reporting period.

Measure 2
More than 5 percent of all unique patients seen by the EP during the EHR reporting period (or their authorized representatives) view, download, or transmit to a third party their health information.

Exclusion1
Neither orders nor creates any of the information listed for inclusion as part of both measures, except for "Patient name" and "Provider's name and office contact information, may exclude both measures.

Exclusion2
Conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 3Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period may exclude only the second measure.

Numerator
The number of unique patients (or their authorized representatives) in the denominator who have viewed online,

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Core measure 8:

Maine Meaningful Use Wizard

Meaningful Use Wizard [CMS Specification Sheet for this measure](#)
Core Measure 8 (EPCMU 08)

Provider: Eggplant, Debbie (NPI: 1212121212) Target: 50 % Provider Percentage: 100 % Pass/Fail 

Objective
Provide clinical summaries for patients for each office visit.

Measure
Clinical summaries provided to patients or patient-authorized representatives within one business day for more than 50 percent of office visits.

Exclusion
Based on ALL patient records: Any EP who has no office visits during the EHR reporting period would be excluded from this requirement. Exclusion from this requirement does not prevent an EP from achieving meaningful use. Does this exclusion apply to No

Numerator
Number of office visits in the denominator where the patient or a patient-authorized representative is provided a clinical summary of their visit within one (1) business day. 10

Denominator
Number of office visits for the EP during the EHR reporting period. 10

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Core measure 8:

Maine Meaningful Use Wizard

Meaningful Use Wizard [CMS Specification Sheet for this measure](#)
Core Measure 9 (EPCMU 09)

Provider: Eggplant, Debbie (NPI: 1212121212) Pass/Fail 

Objective
Protect electronic health information created or maintained by the certified EHR technology (CEHRT) through the implementation of appropriate technical capabilities.

Measure [Note for Documentation](#)
Have you conducted or reviewed a security risk analysis in accordance with the requirements under 45 CFR 164.308(a) (1), including addressing the encryption/security of data stored in CEHRT in accordance with requirements under 45 CFR 164.312 Yes

Note: A security risk analysis must be completed each program year

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Core measure 10:

Maine Meaningful Use Wizard

Core Measure 10 (EPCMU 10)

Provider: Egplant, Debbie (NPI: 1212121212) Target: 55 % Provider Percentage: 100 % Pass/Fail 

[CMS Specification Sheet for this measure](#)

Objective
Incorporate clinical lab-test results into Certified EHR Technology (CEHRT) as structured data.

Measure
More than 55 percent of all clinical lab tests results ordered by the EP during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in Certified EHR Technology as structured data.

Exclusion
Based on ALL patient records: Any EP who orders no lab tests where results are either in a positive/negative affirmation or numeric format during the EHR reporting period. Does this exclusion apply to you?

Numerator
Number of lab test results which are expressed in a positive or negative affirmation or as a numeric result which are incorporated in CEHRT as structured data.

Denominator
Number of lab tests ordered during the EHR reporting period by the EP whose results are expressed in a positive or negative affirmation or as a number.

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Core measure 11:

Maine Meaningful Use Wizard

Core Measure 11 (EPCMU 11)

Provider: Egplant, Debbie (NPI: 1212121212) Pass/Fail 

[CMS Specification Sheet for this measure](#)

Objective
Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research or outreach.

Measure [Note for Documentation](#)
Generate at least one report listing patients of the EP with a specific condition. Have you met this measure?

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Core measure 12:

Maine Meaningful Use Wizard CMS Specification Sheet for this measure

Meaningful Use Wizard
Core Measure 12 (EPCMU 12)

Provider: Egplant, Debbie (NPI: 1212121212) Target: 10% Provider Percentage: 100% Pass/Fail 

Objective
Use clinically relevant information to identify patients who should receive reminders for preventive/follow-up care and send these patients the reminders, per patient preference.

Measure
More than 10 percent of all unique patients who have had 2 or more office visits with the EP within the 24 months before the beginning of the EHR reporting period were sent a reminder, per patient preference when available.

Exclusion
Any EP who has had no office visits in the 24 months before the EHR reporting period. Does this exclusion apply to you?

Numerator
Number of patients in the denominator who were sent a reminder per patient preference when available during the EHR reporting period.

Denominator
Number of unique patients who have had two or more office visits with the EP in the 24 months prior to the beginning

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Core measure 13:

Maine Meaningful Use Wizard CMS Specification Sheet for this measure

Meaningful Use Wizard
Core Measure 13 (EPCMU 13)

Provider: Egplant, Debbie (NPI: 1212121212) Target: 10% Provider Percentage: 100% Pass/Fail 

Objective
Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate.

Measure
Patient-specific education resources identified by Certified EHR Technology are provided to patients for more than 10 percent of all unique patients with office visits seen by the EP during the EHR reporting period.

Exclusion
Any EP who has no office visits during the EHR reporting period.

Numerator
Number of patients in the denominator who were provided patient-specific education resources identified by the Certified EHR Technology.

Denominator [Note on Denominator](#)
Number of unique patients seen by the EP during the EHR reporting period.

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Core measure 14:

Meaningful Use Wizard [CMS Specification Sheet for this measure](#)

Core Measure 14 (EPCMU 14)

Provider: Egplant, Debbie (NPI: 1212121212) Target: 50 % Provider Percentage: 100 % Pass/Fail

Objective
The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation.

Measure
The EP who performs medication reconciliation for more than 50 percent of transitions of care in which the patient is transitioned into the care of the EP.

Exclusion
Any EP who was not the recipient of any transitions of care during the EHR reporting period.

Numerator
The number of transitions of care in the denominator where medication reconciliation was performed.

Denominator
Number of transitions of care during the EHR reporting period for which the EP was the receiving party of the transition.

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Core measure 15:

Meaningful Use Wizard
Core Measure 15 (EPCMU 15)
Provider: Egpllant, Debbie (NPI: 1212121212) Target: 50-10% Provider Percentage: N/A-N/A% Pass/Fail

Objective
The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary care record for each transition of care or referral.

Exclusion
Any EP who transfers a patient to another setting or refers a patient to another provider less than 100 times during the EHR reporting period is excluded from all three measures. Yes

Measure 1
The EP who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50 percent of transitions of care and referrals.

Numerator
The number of transitions of care and referrals in the denominator where a summary of care record was provided. 0

Denominator
Number of transitions of care and referrals during the EHR reporting period for which the EP was the transferring or referring provider. 0

Measure 2
The EP who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 10 percent of such transitions and referrals either (a) electronically transmitted using CEHRT to a recipient or (b) where the recipient receives the summary of care record via exchange facilitated by an organization that is a NwHIN Exchange participant or in a manner that is consistent with the governance mechanism ONC establishes for the NwHIN.

Numerator
The number of transitions of care and referrals in the denominator where a summary of care record was a) electronically transmitted using CEHRT to a recipient or b) where the recipient receives the summary of care record via exchange facilitated by an organization that is a NwHIN Exchange participant or in a manner that is consistent with the governance mechanism ONC establishes for the nationwide health information network. The organization can be a third-party or the sender's own organization. 0

Denominator
Number of transitions of care and referrals during the EHR reporting period for which the EP was the transferring or referring provider. 0

Measure 3 [Note for Documentation](#)
Have you met one of the two criteria below? No

Have you conducted one or more successful electronic exchanges of a summary of care document, part of which is counted in "measure 2" (for EPs the measure at §495.6(j)(14)(ii)(B), with a recipient who has EHR technology that was designed by a different EHR technology developer than the sender's EHR technology certified to 45 CFR 170.314(b)(2)?

OR

Conducts one or more successful tests with the CMS designated test EHR during the EHR reporting period.

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- Additional information available for this measure includes a guide for providers to complete the PH registries. In Maine the public health department is called CDC. The [CDC Measures and Meaningful Use](#) guide is located in the upper right corner of the page

Core measure 16:

Meaningful Use Wizard
Core Measure 16 (EPCMU 16)
Provider: Eqplant, Debbie (NPI: 1212121212) Pass/Fail

[CMS Specification Sheet for this measure](#)
[CDC Measures and Meaningful Use](#)

Objective
Capability to submit electronic data to immunization registries or immunization information systems except where prohibited, and in accordance with applicable law and practice.

Measure [Note for Documentation](#)
Successful ongoing submission of electronic immunization data from CEHRT to an immunization registry or immunization information system for the entire EHR reporting period. Yes

Exclusion 1
The EP does not administer any of the immunizations to any of the populations for which data is collected by their jurisdiction's immunization registry or immunization information system during the EHR reporting period. Does this exclusion apply to you? No

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Core measure 17:

Meaningful Use Wizard
Core Measure 17 (EPCMU 17)
Provider: Eqplant, Debbie (NPI: 1212121212) Target: 5% Provider Percentage: N/A Pass/Fail

[CMS Specification Sheet for this measure](#)

Objective
Use secure electronic messaging to communicate with patients on relevant health information.

Measure
A secure message was sent using the electronic messaging function of CEHRT by more than 5 percent of unique patients (or their authorized representatives) seen by the EP during the EHR reporting period.

Exclusion
Any EP who has no office visits during the EHR reporting period, or any EP who conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 3Mbps broadband availability according to the Yes

Numerator
The number of patients or patient-authorized representatives in the denominator who send a secure electronic message to the EP that is received using the electronic messaging function of CEHRT during the EHR reporting period. 0

Denominator [Note on Denominator](#)
Number of unique patients seen by the EP during the EHR reporting period. 0

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C3d2b. Menu Measures

C3d2b1. Resources for Providers

- The upper right corner of the page has a link to download a document for Stage 2 (2014 MU submissions): [Menu Measure Overview](#)
- Maine developed a wizard application for providers to register for the Public Health registries. This page contains a link to download that application as well as a guide to the PH registry process (2014 MU submissions)
 - [Download the CDC Registration Wizard](#)
 - [Entering Meaningful Use Information for measures relating to the Maine CDC Health Registries](#)

C3d2b2. Stage 2 Menu Measures

Menu Measures [Menu Measure Overview](#)

Menu Measures Section

Provider: Eqplant, Debbie (NPI: 1212121212)

Section 2: Menu Measures.

Three out of Six Menu Measures must be met according to the CMS threshold.

- In 2014, EPs, eligible hospitals, and CAHs are not permitted to count an exclusion toward the minimum of 3 menu objectives on which they must report if there are other menu objectives which they can select and meet.
- Exception - If an EP cannot complete 3 of the menu measures without exclusion you may still meet Meaningful Use requirements by answering all 6 of the menu measures taking whatever exclusions necessary.
- Note: Menu measures 1 and 5 can be met by registering your intent to submit ongoing data submission on the Maine CDC registration site. Please click the link below to download the CDC registration wizard.
[Download the CDC Registration Wizard.](#)
 Using the CDC Registration Wizard you can register for all available public health registries at one time. Please follow the directions in the wizard to complete your registrations. Retain the acknowledgement email you receive as documentation that you have registered.
For more information on Meaningful Use measures involving the CDC Health Registries please refer to the document linked below:
[Entering Meaningful Use information for measures relating to the Maine CDC Health Registries.](#)
If your practice does not plan on fully onboarding for a particular public health menu measure please do not register for that registry.

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Provider selects a minimum of 3 from the available 6 Menu Measures

Menu Measures

Select Menu Measures from the list below

Provider: Eqplant, Debbie (NPI: 1212121212)

Menu Measures

Please select at least 3 of the 6 Menu Measures below.

Select	Measure Code	Measure
<input type="checkbox"/>	EPMMU 01	Successful ongoing submission of electronic syndromic surveillance data from CEHRT to a public health agency for the entire EHR reporting period.
<input checked="" type="checkbox"/>	EPMMU 02	Enter at least one electronic progress note created, edited and signed by an EP for more than 30 percent of unique patients with at least one office visit during the EHR Measure reporting period. The text of the electronic note must be text searchable and may contain drawings and other content
<input checked="" type="checkbox"/>	EPMMU 03	More than 10 percent of all tests whose result is one or more images ordered by the EP during the EHR reporting period are accessible through CEHRT.
<input checked="" type="checkbox"/>	EPMMU 04	More than 20 percent of all unique patients seen by the EP during the EHR reporting period have a structured data entry for one or more first-degree relatives.
<input type="checkbox"/>	EPMMU 05	Have you been successful with ongoing submission of cancer case information from CEHRT to a public health central cancer registry for the entire EHR reporting period?
<input type="checkbox"/>	EPMMU 05	Have you been successful with ongoing submission of cancer case information from CEHRT to a public health central cancer registry for the entire EHR reporting period?
<input type="checkbox"/>	EPMMU 06	Have you been successful with ongoing submission of specific case information from CEHRT to a specialized registry for the entire EHR reporting period?

[Select F3 for Jaws Screen Reader Help](#) < Back Next > Cancel

Menu measure 1: Note the additional information available for the Public Health registry as well as the note for documentation

Maine Meaningful Use Wizard

Menu Measure (EPMMU 01)

Provider: Egplant, Debbie (NPI: 1212121212)

Pass/Fail

[CMS Specification Sheet for this measure](#)
[CDC Measures and Meaningful Use](#)

Objective
Capability to submit electronic syndromic surveillance data to public health agencies except where prohibited, and in accordance with applicable law and practice.

Measure [Note for Documentation](#)
Successful ongoing submission of electronic syndromic surveillance data from CEHRT to a public health agency for the entire EHR reporting period. Yes

Exclusion 1
The EP is not in a category of providers that collect ambulatory syndromic surveillance information on their patients during the EHR reporting period. Does this exclusion apply to you? No

Select F3 for Jaws Screen Reader Help

< Back Next > Cancel

Menu measure 2:

Maine Meaningful Use Wizard

Menu Measure (EPMMU 02)

Provider: Egplant, Debbie (NPI: 1212121212)

Target: 30 % Provider Percentage: 50 %

Pass/Fail

[CMS Specification Sheet for this measure](#)

Objective
Record electronic notes in patient records.

Measure
Enter at least one electronic progress note created, edited and signed by an EP for more than 30 percent of unique patients with at least one office visit during the EHR

Exclusion 1
The EP has no office visits during the EHR reporting period. No

Numerator
The number of unique patients in the denominator who have at least one electronic progress note from an eligible professional recorded as text searchable data. 5

Denominator [Note on Denominator](#)
Number of unique patients with at least one office visit during the EHR reporting period for EPs during the EHR reporting period. 10

Select F3 for Jaws Screen Reader Help

< Back Next > Cancel

Menu measure: 3

Maine Meaningful Use Wizard

Menu Measure (EPMMU 03)

Provider: Eqplant, Debbie (NPI: 1212121212) Target: 10 % Provider Percentage: 33.33 % Pass/Fail

Objective
Imaging results consisting of the image itself and any explanation or other accompanying information are accessible through CEHRT.

Measure
More than 10 percent of all tests whose result is one or more images ordered by the EP during the EHR reporting period are accessible through CEHRT.

Exclusion
Any EP who orders less than 100 tests whose result is an image during the EHR reporting period; or any EP who has no access to electronic imaging results at the start of the EHR reporting period. Does this exclusion apply to you? No

Numerator
The number of results in the denominator that are accessible through CEHRT. 2

Denominator
Number of tests whose result is one or more images ordered by the EP during the EHR reporting period. 6

Select F3 for Jaws Screen Reader Help

< Back Next > Cancel

Menu measure: 4

Maine Meaningful Use Wizard

Menu Measure (EPMMU 04)

Provider: Eqplant, Debbie (NPI: 1212121212) Target: 20 % Provider Percentage: 50 % Pass/Fail

Objective
Record patient family health history as structured data.

Measure
More than 20 percent of all unique patients seen by the EP during the EHR reporting period have a structured data entry for one or more first-degree relatives.

Exclusion
Any EP who has no office visits during the EHR reporting period. No

Numerator
The number of patients in the denominator with a structured data entry for one or more first-degree relatives. 5

Denominator [Note on Denominator](#)
Number of unique patients seen by the EP during the EHR reporting period. 10

Select F3 for Jaws Screen Reader Help

< Back Next > Cancel

Menu measure: 5

Maine Meaningful Use Wizard

Meaningful Use Wizard
Menu Measure (EPMMU 05)

[CMS Specification Sheet for this measure](#)
[CDC Measures and Meaningful Use](#)

Provider: Egplant, Debbie (NPI: 1212121212) Pass/Fail

Objective
Capability to identify and report cancer cases to a public health central cancer registry, except where prohibited, and in accordance with applicable law and practice.

Measure [Note for Documentation](#)
Have you been successful with ongoing submission of cancer case information from EHR to a public health central cancer registry for the entire EHR reporting period? Yes ▾

Exclusion 1
The EP does not diagnose or directly treat cancer. Does this exclusion apply to you? No ▾

Select F3 for Jaws Screen Reader Help

< Back Next > Cancel

Summary of provider progress for menu measure requirements

Maine Meaningful Use Wizard

Meaningful Use Wizard
Menu Measure Summary

Provider: Egplant, Debbie (NPI: 1212121212)

Menu Measure Summary.

EPs must report on 3 of the 6 Menu Measures without exclusions.

Number of Measures Selected	3
Number of Measures Selected without Exclusions	3

Congratulations! You have completed the Core and Menu Measures section. You may now continue and enter your data for the Clinical Quality Measures.

Select F3 for Jaws Screen Reader Help

< Back Next > Cancel

C3d2c . Clinical Quality Measures (CQM)

C3d2c1. Resources for Providers

- The upper right corner of the page has a link to download a document for CQM Overview

C3d2c2. Stage 2 Clinical Quality Measures

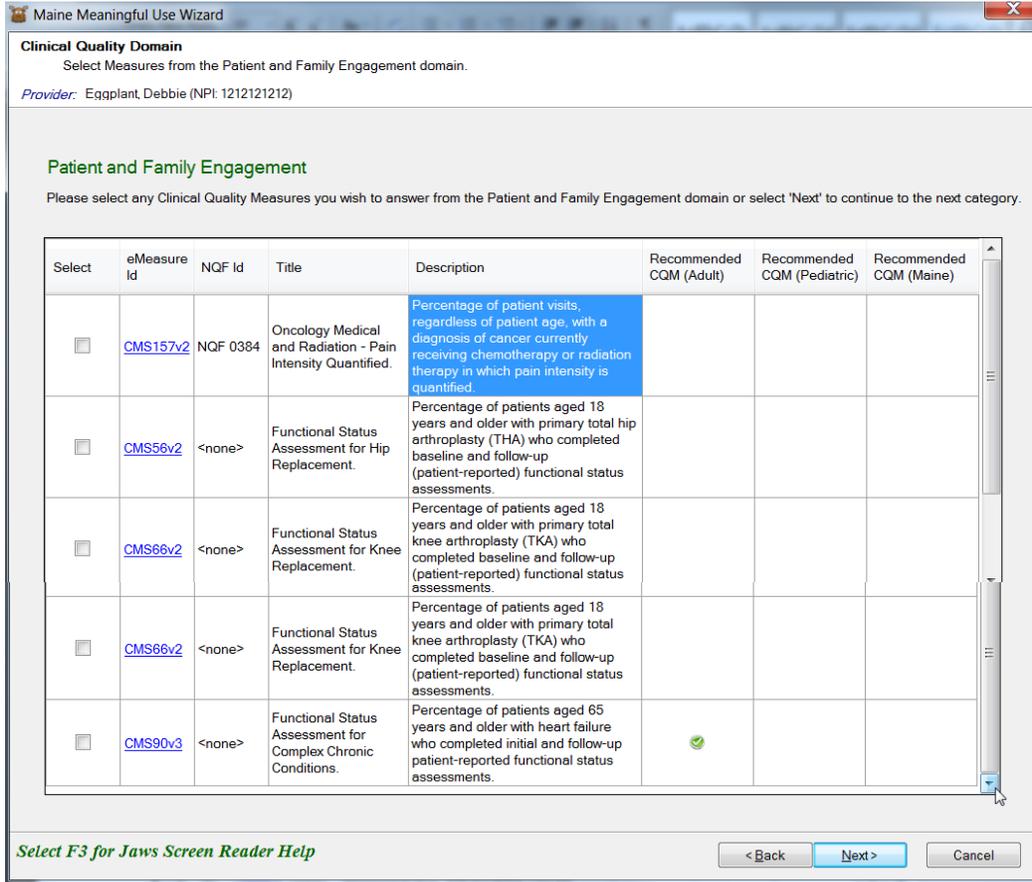
CQM instruction page

The screenshot shows a window titled "Maine Meaningful Use Wizard" with a sub-header "Clinical Quality Measures" and a link for "CQM Overview". The provider information is "Eqqplant, Debbie (NPI: 1212121212)". The section is titled "Section 3: Clinical Quality Measures." and states "EPs must report on 9 of the 64 approved CQMs." It lists nine National Quality Strategy domains: Patient and Family Engagement, Patient Safety, Care Coordination, Population and Public Health, Efficient Use of Healthcare Resources, and Clinical Processes/Effectiveness. It also notes that 9 recommended adult and 9 recommended pediatric CQMs are available, with a note about NQF 0018 and NQF 0059. At the bottom, there is a green link "Select F3 for Jaws Screen Reader Help" and navigation buttons for "< Back", "Next >", and "Cancel".

- CQMs are broken out by the domain they are listed under
- If a CQM is a recommended adult, pediatric or Maine measure that is noted by a green check mark
- Each CQM measure has a link to click on the selection page as well as on the CQM page for detail information for that measure
- Sample CQM detail: [CMS157v2](#)
- A provider selects the CQM measure they will submit data for
- Each CQM measure includes a summary at the top of the page showing the provider their progress for meeting the CQM requirements, these are updated as the provider continues to input data

Meaningful Use Wizard	CMS Specification Sheet for this measure
Clinical Quality Measure CMS56v2 (No NQF code assigned to this measure)	
Provider: Eqqplant, Debbie (NPI: 1212121212)	Msrs Req. 9 Msrs Slctd. 4 Dms Req. 3 Dms Slctd. 3

Patient and Family Engagement – 5 available CQMs



- Screen shots for the CQM measures are resized to show the measure information only

CMS 157v2 – NQF 0384



CMS 56v2

Meaningful Use Wizard

Clinical Quality Measure CMS56v2 (No NQF code assigned to this measure)

[CMS Specification Sheet for this measure](#)

Provider: Eqaplant,Debbie (NPI: 1212121212)

Mrs Req. 9

Mrs Sctd. 4

Dms Req. 3

Dms Sctd. 3

Title

Functional Status Assessment for Hip Replacement.

Description

Percentage of patients aged 18 years and older with primary total hip arthroplasty (THA) who completed baseline and follow-up (patient-reported) functional status

Complete the following information:

Numerator:

Denominator:

Exclusion:

CMS 66v2

Meaningful Use Wizard

Clinical Quality Measure CMS66v2 (No NQF code assigned to this measure)

[CMS Specification Sheet for this measure](#)

Provider: Eqaplant,Debbie (NPI: 1212121212)

Mrs Req. 9

Mrs Sctd. 4

Dms Req. 3

Dms Sctd. 3

Title

Functional Status Assessment for Knee Replacement.

Description

Percentage of patients aged 18 years and older with primary total knee arthroplasty (TKA) who completed baseline and follow-up (patient-reported) functional status

Complete the following information:

Numerator:

Denominator:

Exclusion:

CMS 90v3

Meaningful Use Wizard

Clinical Quality Measure CMS90v3 (No NQF code assigned to this measure)

[CMS Specification Sheet for this measure](#)

Provider: Eqaplant,Debbie (NPI: 1212121212)

Mrs Req. 9

Mrs Sctd. 4

Dms Req. 3

Dms Sctd. 3

Title

Functional Status Assessment for Complex Chronic Conditions.

Description

Percentage of patients aged 65 years and older with heart failure who completed initial and follow-up patient-reported functional status assessments.

Complete the following information:

Numerator:

Denominator:

Exclusion:

Patient Safety – 6 available CQMs

Patient Safety

Please select any Clinical Quality Measures you wish to answer from the Patient Safety domain or select 'Next' to continue to the next category.

Select	eMeasure Id	NQF Id	Title	Description	Recommended CQM (Adult)	Recommended CQM (Pediatric)	Recommended CQM (Maine)
<input checked="" type="checkbox"/>	CMS132v2	NQF 0564	Cataracts: Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures.	Percentage of patients aged 18 years and older with a diagnosis of uncomplicated cataract who had cataract surgery and had any of a specified list of surgical procedures in the 30 days following cataract surgery which would indicate the occurrence of any of the following major complications: retained nuclear fragments, endophthalmitis, dislocated or wrong power IOL, retinal detachment, or wound dehiscence			
<input type="checkbox"/>	CMS139v2	NQF 0101	Falls: Screening for Future Fall Risk	Percentage of patients 65 years of age and older who were screened for future fall risk during the measurement period.			
<input type="checkbox"/>	CMS156v2	NQF 0022	Use of High-Risk Medications in the Elderly.	Percentage of patients 65 years of age and older who were ordered high-risk medications. Two rates are reported. a. Percentage of patients who were ordered at least one high-risk medication. b. Percentage of patients who were ordered at least two different high-risk medications.			
<input type="checkbox"/>	CMS177v2	NQF 1365	Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment.	Percentage of patient visits for those patients aged 6 through 17 years with a diagnosis of major depressive disorder with an assessment for suicide risk.			
<input type="checkbox"/>	CMS179v2	<none>	ADE Prevention and Monitoring: Warfarin Time in Therapeutic Range.	Average percentage of time in which patients aged 18 and older with atrial fibrillation who are on chronic warfarin therapy have International Normalized Ratio (INR) test results within the therapeutic range (i.e., TTR) during the measurement period.			
<input type="checkbox"/>	CMS58v3	NQF 0419	Documentation of Current Medications in the Medical Record.	Percentage of visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration.			

Meaningful Use Wizard

Clinical Quality Measure CMS132v2 (NQF 0564)

[CMS Specification Sheet for this measure](#)

Provider: Eggplant, Debbie (NPI: 1212121212)

Msrs Req. 9

Msrs Slctd. 4

Dms Req. 3

Dms Slctd. 3

Title

Cataracts: Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures.

Description

Percentage of patients aged 18 years and older with a diagnosis of uncomplicated cataract who had cataract surgery and had any of a specified list of surgical procedures which would indicate the occurrence of any of the following major complications: retained nuclear fragments, endophthalmitis, dislocated or wrong power IO

Complete the following information:

Numerator:

Denominator:

Exclusion:

Meaningful Use Wizard[CMS Specification Sheet for this measure](#)

Clinical Quality Measure CMS139v2 (NQF 0101)

Provider: Eggplant, Debbie (NPI: 1212121212)*Mrs Req.* 9*Mrs Slctd.* 4*Dms Req.* 3*Dms Slctd.* 3**Title**

Falls: Screening for Future Fall Risk

Description

Percentage of patients 65 years of age and older who were screened for future fall risk during the measurement period.

Complete the following information:

Numerator: Denominator: Exception: **Meaningful Use Wizard**[CMS Specification Sheet for this measure](#)

Clinical Quality Measure CMS156v2 (NQF 0022)

Provider: Eggplant, Debbie (NPI: 1212121212)*Mrs Req.* 9*Mrs Slctd.* 4*Dms Req.* 3*Dms Slctd.* 3**Title**

Use of High-Risk Medications in the Elderly.

Description

Percentage of patients 66 years of age and older who were ordered high-risk medications.

Two rates are reported.

a. Percentage of patients who were ordered at least one high-risk medication.

b. Percentage of patients who were ordered at least two different high-risk medications.

Complete the following information:

Numerator 1: Denominator: Numerator 2: Denominator: **Meaningful Use Wizard**[CMS Specification Sheet for this measure](#)

Clinical Quality Measure CMS177v2 (NQF 1365)

Provider: Eggplant, Debbie (NPI: 1212121212)*Mrs Req.* 9*Mrs Slctd.* 4*Dms Req.* 3*Dms Slctd.* 3**Title**

Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment.

Description

Percentage of patient visits for those patients aged 6 through 17 years with a diagnosis of major depressive disorder with an assessment for suicide risk.

Complete the following information:

Numerator: Denominator:

Meaningful Use Wizard

[CMS Specification Sheet for this measure](#)

Clinical Quality Measure CMS179v2 (No NQF code assigned to this measure)

Provider: Eggplant, Debbie (NPI: 1212121212)

Mrs Req. 9

Mrs Slctd. 4

Dms Req. 3

Dms Slctd. 3

Title

ADE Prevention and Monitoring: Warfarin Time in Therapeutic Range.

Description

Average percentage of time in which patients aged 18 and older with atrial fibrillation who are on chronic warfarin therapy have International Normalized Ratio (INR) test results within the therapeutic range (i.e., TTR) during the measurement period.

Complete the following information:

Percent:

Meaningful Use Wizard

[CMS Specification Sheet for this measure](#)

Clinical Quality Measure CMS68v3 (NQF 0419)

Provider: Eggplant, Debbie (NPI: 1212121212)

Mrs Req. 9

Mrs Slctd. 4

Dms Req. 3

Dms Slctd. 3

Title

Documentation of Current Medications in the Medical Record.

Description

Percentage of visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications using all immediate r encounter. This list must include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the m route of administration.

Complete the following information:

Numerator:

Denominator:

Exception:

Care Coordination – 1 available CQM

Clinical Quality Domain

Select Measures from the Care Coordination domain.

Provider: Eggplant, Debbie (NPI: 1212121212)

Care Coordination

Please select any Clinical Quality Measures you wish to answer from the Care Coordination domain or select 'Next' to continue to the next category.

Select	eMeasure Id	NQF Id	Title	Description	Recommended CQM (Adult)	Recommended CQM (Pediatric)	Recommended CQM (Maine)
<input type="checkbox"/>	CMS50v2	<none>	Closing the referral loop: receipt of specialist report.	Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred.			

Meaningful Use Wizard

[CMS Specification Sheet for this measure](#)

Clinical Quality Measure CMS50v2 (No NQF code assigned to this measure)

Provider: Eggplant, Debbie (NPI: 1212121212)

Mrs Req. 9

Mrs Slctd. 4

Dms Req. 3

Dms Slctd. 3

Title

Closing the referral loop: receipt of specialist report.

Description

Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred.

Complete the following information:

Numerator:

Denominator:

Population/Public Health – 8 available CQMs

Population/Public Health

Please select any Clinical Quality Measures you wish to answer from the Population/Public Health domain or select 'Next' to continue to the next category.

Select	eMeasure Id	NQF Id	Title	Description	Recommended CQM (Adult)	Recommended CQM (Pediatric)	Recommended CQM (Maine)
<input type="checkbox"/>	CMS22v2	<none>	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented.	Percentage of patients aged 18 years and older seen during the reporting period who were screened for high blood pressure AND a recommended follow-up plan is documented based on the current blood pressure (BP) reading as indicated.			
<input type="checkbox"/>	CMS82v1	NQF 1401	Maternal Depression Screening	The percentage of children who turned 6 months of age during the measurement year, who had a face-to-face visit between the clinician and the child during child's first 6 months, and who had a maternal depression screening for the mother at least once between 0 and 6 months of life.			
<input type="checkbox"/>	CMS138v2	NQF 0028	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention.	Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user.			
<input type="checkbox"/>	CMS69v2	NQF 0421	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up.	Percentage of patients aged 18 years and older with a documented BMI during the encounter or during the previous six months, AND when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the encounter. Normal Parameters: -Age 65 years and older BMI => 23 and < 30 -Age 18 - 64 years BMI => 18.5 and < 25			
<input type="checkbox"/>	CMS155v2	NQF 0024	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents.	Percentage of patients 3-17 years of age who had an outpatient visit with a Primary Care Physician (PCP) or Obstetrician/Gynecologist (OB/GYN) and who had evidence of the following during the measurement period. Three rates are reported. - Percentage of patients with height, weight, and body mass index (BMI) percentile documentation - Percentage of patients with counseling for nutrition - Percentage of patients with counseling for physical activity			
<input type="checkbox"/>	CMS147v2	NQF 0041	Preventive Care and Screening: Influenza Immunization.	Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization.			
<input type="checkbox"/>	CMS117v2	NQF 0038	Childhood Immunization Status.	Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV), one measles, mumps and rubella (MMR); three H influenza type B (HiB); three hepatitis B (Hep B); one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.			
<input type="checkbox"/>	CMS153v2	NQF 0033	Chlamydia Screening for Women	Percentage of women 16-24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement period.			

Meaningful Use Wizard

[CMS Specification Sheet for this measure](#)

Clinical Quality Measure CMS22v2 (No NQF code assigned to this measure)

Provider: Egplant, Debbie (NPI: 1212121212)

Mrs Req. 9

Mrs Slctd. 3

Dms Req. 3

Dms Slctd. 2

Title

Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented.

Description

Percentage of patients aged 18 years and older seen during the reporting period who were screened for high blood pressure AND a recommended follow-up plan i
pressure (BP) reading as indicated.

Complete the following information:

Numerator:

Denominator:

Exclusion:

Exception:

Meaningful Use Wizard

[CMS Specification Sheet for this measure](#)

Clinical Quality Measure CMS82v1 (NQF 1401)

Provider: Egplant, Debbie (NPI: 1212121212)

Mrs Req. 9

Mrs Slctd. 3

Dms Req. 3

Dms Slctd. 2

Title

Maternal Depression Screening

Description

The percentage of children who turned 6 months of age during the measurement year, who had a face-to-face visit between the clinician and the child during child
depression screening for the mother at least once between 0 and 6 months of life.

Complete the following information:

Numerator:

Denominator:

Meaningful Use Wizard

[CMS Specification Sheet for this measure](#)

Clinical Quality Measure CMS138v2 (NQF 0028)

Provider: Eggplant, Debbie (NPI: 1212121212)

Mrs Req. 9

Mrs Slctd. 3

Dms Req. 3

Dms Slctd. 2

Title

Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention.

Description

Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling in

Complete the following information:

Numerator:

Denominator:

Exception:

Meaningful Use Wizard

[CMS Specification Sheet for this measure](#)

Clinical Quality Measure CMS69v2 (NQF 0421)

Provider: Eggplant, Debbie (NPI: 1212121212)

Mrs Req. 9

Mrs Slctd. 3

Dms Req. 3

Dms Slctd. 2

Title

Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up.

Description

Percentage of patients aged 18 years and older with a documented BMI during the encounter or during the previous six months, AND when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the encounter.

Complete the following information:

Part A: 65 and older

Numerator

Denominator

Exclusion

Part B: 18-64 years old

Numerator

Denominator

Exclusion

Meaningful Use Wizard[CMS Specification Sheet for this measure](#)

Clinical Quality Measure CMS155v2 (NQF 0024)

Provider: Eggplant, Debbie (NPI: 1212121212)*Msrs Req.* 9*Msrs Slctd.* 3*Dms Req.* 3*Dms Slctd.* 2**Title**

Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents.

Description

Percentage of patients 3-17 years of age who had an outpatient visit with a Primary Care Physician (PCP) or Obstetrician/Gynecologist (OB/GYN) and who had evidence of the following during the measurement period.

Complete the following information:

Population Criteria 1:

Numerator 1:

Denominator

Numerator 2:

Denominator

Numerator 3:

Denominator

Population Criteria 2:

Numerator 1:

Denominator

Meaningful Use Wizard[CMS Specification Sheet for this measure](#)

Clinical Quality Measure CMS147v2 (NQF 0041)

Provider: Eggplant, Debbie (NPI: 1212121212)*Msrs Req.* 9*Msrs Slctd.* 3*Dms Req.* 3*Dms Slctd.* 2**Title**

Preventive Care and Screening: Influenza Immunization.

Description

Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previo

Complete the following information:

Numerator:

Denominator:

Exception:

Meaningful Use Wizard

[CMS Specification Sheet for this measure](#)

Clinical Quality Measure CMS117v2 (NQF 0038)

Provider: Eggplant, Debbie (NPI: 1212121212)

Msrs Req. 9

Msrs Slctd. 3

Dms Req. 3

Dms Slctd. 2

Title

Childhood Immunization Status.

Description

Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV), one measles, mumps and rubella (MMR); t hepatitis B (Hep B); one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccin

Complete the following information:

Numerator:

Denominator:

Meaningful Use Wizard

[CMS Specification Sheet for this measure](#)

Clinical Quality Measure CMS153v2 (NQF 0033)

Provider: Eggplant, Debbie (NPI: 1212121212)

Msrs Req. 9

Msrs Slctd. 3

Dms Req. 3

Dms Slctd. 2

Title

Chlamydia Screening for Women

Description

Percentage of women 16-24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement period.

Complete the following information:

Population Criteria 1 **Numerator 1:** **Denominator:** **Exclusion:**

Population Criteria 2 **Numerator 2:** **Denominator:** **Exclusion:**

Efficient Use of Healthcare 4 available CQMs

Efficient Use of Healthcare Resources

Please select any Clinical Quality Measures you wish to answer from the Efficient Use of Healthcare Resources domain or select 'Next' to continue to the n

Select	eMeasure Id	NQF Id	Title	Description	Recommended CQM (Adult)	Recommended CQM (Pediatric)	Recommended CQM (Maine)
<input type="checkbox"/>	CMS146v2	NQF 0002	Appropriate Testing for Children with Pharyngitis	Percentage of children 2-18 years of age who were diagnosed with pharyngitis, ordered an antibiotic and received a group A streptococcus (strep) test for the episode.			
<input type="checkbox"/>	CMS166v3	NQF 0052	Use of Imaging Studies for Low Back Pain.	Percentage of patients 18-50 years of age with a diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis.			
<input type="checkbox"/>	CMS154v2	NQF 0069	Appropriate Treatment for Children with Upper Respiratory Infection (URI).	Percentage of children 3 months-18 years of age who were diagnosed with upper respiratory infection (URI) and were not dispensed an antibiotic prescription on or three days after the episode.			
<input type="checkbox"/>	CMS129v3	NQF 0389	Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients.	Percentage of patients, regardless of age, with a diagnosis of prostate cancer at low risk of recurrence receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy who did not have a bone scan performed at any time since diagnosis of prostate cancer.			

Meaningful Use Wizard

Clinical Quality Measure CMS146v2 (NQF 0002)

[CMS Specification Sheet for this measure](#)

Provider: Eggplant, Debbie (NPI: 1212121212)

Mrs Req. 9

Mrs Slctd. 4

Dms Req. 3

Dms Slctd. 3

Title

Appropriate Testing for Children with Pharyngitis

Description

Percentage of children 2-18 years of age who were diagnosed with pharyngitis, ordered an antibiotic and received a group A streptococcus (strep) test for the epis

Complete the following information:

Numerator:

Denominator:

Exclusion:

Meaningful Use Wizard[CMS Specification Sheet for this measure](#)

Clinical Quality Measure CMS166v3 (NQF 0052)

Provider: Eggplant, Debbie (NPI: 1212121212)*Msrs Req.* 9*Msrs Slctd.* 4*Dms Req.* 3*Dms Slctd.* 3**Title**

Use of Imaging Studies for Low Back Pain.

Description

Percentage of patients 18-50 years of age with a diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the dia

Complete the following information:

Numerator: Denominator: Exclusion: **Meaningful Use Wizard**[CMS Specification Sheet for this measure](#)

Clinical Quality Measure CMS154v2 (NQF 0069)

Provider: Eggplant, Debbie (NPI: 1212121212)*Msrs Req.* 9*Msrs Slctd.* 4*Dms Req.* 3*Dms Slctd.* 3**Title**

Appropriate Treatment for Children with Upper Respiratory Infection (URI).

Description

Percentage of children 3 months-18 years of age who were diagnosed with upper respiratory infection (URI) and were not dispensed an antibiotic prescription on or

Complete the following information:

Numerator: Denominator: Exclusion: **Meaningful Use Wizard**[CMS Specification Sheet for this measure](#)

Clinical Quality Measure CMS129v3 (NQF 0389)

Provider: Eggplant, Debbie (NPI: 1212121212)*Msrs Req.* 9*Msrs Slctd.* 4*Dms Req.* 3*Dms Slctd.* 3**Title**

Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients.

Description

Percentage of patients, regardless of age, with a diagnosis of prostate cancer at low risk of recurrence receiving interstitial prostate brachytherapy, OR external beam prostatectomy, OR cryotherapy who did not have a bone scan performed at any time since diagnosis of prostate cancer.

Complete the following information:

Numerator: Denominator: Exception:

Clinical Process /Effectiveness 41available CQMS

Select	eMeasure Id	NQF Id	Title	Description	Recommended CQM (Adult)	Recommended CQM (Pediatric)	Recommended CQM (Maine)
<input type="checkbox"/>	CMS137v2	NQF 0004	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment.	Percentage of patients 13 years of age and older with a new episode of alcohol and other drug (AOD) dependence who received the following. Two rates are reported. a. Percentage of patients who initiated treatment within 14 days of the diagnosis. b. Percentage of patients who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit.			
<input type="checkbox"/>	CMS165v2	NQF 0018	Controlling High Blood Pressure	Percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90mmHg) during the measurement period.			
<input type="checkbox"/>	CMS125v2	NQF 0031	Breast Cancer Screening	The percentage of women 40-69 years of age who had a mammogram to screen for breast cancer.			
<input type="checkbox"/>	CMS124v2	NQF 0032	Cervical Cancer Screening	Percentage of women 21-64 years of age, who received one or more Pap tests to screen for cervical cancer.			
<input type="checkbox"/>	CMS130v2	NQF 0034	Colorectal Cancer Screening	The percentage of adults 50-75 years of age who had appropriate screening for colorectal cancer.			
<input type="checkbox"/>	CMS126v2	NQF 0036	Use of Appropriate Medications for Asthma	Percentage of patients 5-64 years of age who were identified as having persistent asthma and were appropriately prescribed medication during the measurement period.			
<input type="checkbox"/>	CMS127v2	NQF 0043	Pneumonia Vaccination Status for Older Adults	The percentage of patients 65 years of age and older who have ever received a pneumococcal vaccine.			
<input type="checkbox"/>	CMS131v2	NQF 0055	Diabetes: Eye Exam	Percentage of patients 18-75 years of age with diabetes who had a retinal or dilated eye exam by an eye care professional during the measurement period or a negative retinal exam (no evidence of retinopathy) in the 12 months prior to the measurement period.			
<input type="checkbox"/>	CMS123v2	NQF 0056	Diabetes: Foot Exam	Percentage of patients aged 18-75 years of age with diabetes who had a foot exam during the measurement period.			
<input type="checkbox"/>	CMS122v2	NQF 0059	Diabetes: HbA1c Poor Control	The percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had HbA1c >9.0%.			
<input type="checkbox"/>	CMS148v2	NQF 0060	Hemoglobin A1c Test for Pediatric Patients.	Percentage of patients 5-17 years of age with diabetes with an HbA1c test during the measurement period.			
<input type="checkbox"/>	CMS134v2	NQF 0062	Diabetes: Urine Protein Screening.	The percentage of patients 18-75 years of age with diabetes who had a nephropathy screening test or evidence of nephropathy during the measurement period.			

<input type="checkbox"/>	CMS163v2	NQF 0064	Diabetes: Low Density Lipoprotein (LDL) Management.	Percentage of patients 18-75 years of age with diabetes whose LDL-C was adequately controlled (<100 mg/dL) during the measurement period.			
<input type="checkbox"/>	CMS164v2	NQF 0068	Ischemic Vascular Disease (IVD): Use of Aspirin or another Antithrombotic	Percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) in the 12 months prior to the measurement period, or who had an active diagnosis of ischemic vascular disease (IVD) during the measurement period, and who had documentation of use of aspirin or another antithrombotic during the measurement period.			
<input type="checkbox"/>	CMS145v2	NQF 0070	Coronary Artery Disease (CAD): Beta-Blocker Therapy Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF <40%).	Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12 month period who also have a prior MI or a current or prior LVEF <40% who were prescribed beta-blocker therapy.			
<input type="checkbox"/>	CMS182v3	NQF 0075	Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control.	Percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) in the 12 months prior to the measurement period, or who had an active diagnosis of ischemic vascular disease (IVD) during the measurement period, and who had a complete lipid profile performed during the measurement period and whose LDL-C was adequately controlled (< 100 mg/dL).			
<input type="checkbox"/>	CMS135v2	NQF 0081	Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD).	Percentage of patients aged 18 years and older with a diagnosis of heart failure (HF) with a current or prior left ventricular ejection fraction (LVEF) < 40% who were prescribed ACE inhibitor or ARB therapy either within a 12 month period when seen in the outpatient setting OR at each hospital discharge.			
<input type="checkbox"/>	CMS144v2	NQF 0083	Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD).	Percentage of patients aged 18 years and older with a diagnosis of heart failure (HF) with a current or prior left ventricular ejection fraction (LVEF) < 40% who were prescribed beta-blocker therapy either within a 12 month period when seen in the outpatient setting OR at each hospital discharge.			
<input type="checkbox"/>	CMS143v2	NQF 0086	Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation	Percentage of patients aged 18 years and older with a diagnosis of primary open-angle glaucoma (POAG) who have an optic nerve head evaluation during one or more office visits within 12 months.			
<input type="checkbox"/>	CMS167v2	NQF 0088	Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy	Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed which included documentation of the level of severity of retinopathy and the presence or absence of macular edema during one or more office visits within 12 months.			

<input type="checkbox"/>	CMS142v2	NQF 0089	Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care	Percentage of patients aged 18 through 80 years with AJCC Stage III colon cancer who are referred for adjuvant chemotherapy, prescribed adjuvant chemotherapy, or have previously received adjuvant chemotherapy within the 12-month reporting period.			
<input type="checkbox"/>	CMS161v2	NQF 0104	Adult Major Depressive Disorder (MDD): Suicide Risk Assessment.	Percentage of patients aged 18 years and older with a diagnosis of major depressive disorder (MDD) with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified.			
<input type="checkbox"/>	CMS128v2	NQF 0105	Anti-depressant Medication Management.	Percentage of patients 18 years of age and older who were diagnosed with major depression and treated medication, and who remained on antidepressant medication treatment. Two rates are reported. a. Percentage of patients who remained on an antidepressant medication for at least 84 days (12 weeks). b. Percentage of patients who remained on an antidepressant medication for at least 180 days (6 months).			
<input type="checkbox"/>	CMS136v3	NQF 0108	ADHD: Follow-Up Care for Children Prescribed Attention-Deficit/Hyper Disorder (ADHD) Medication.	Percentage of children 6-12 years of age and newly dispensed a medication for attention-deficit/hyperactivity disorder (ADHD) who had appropriate follow-up care. Two rates are reported. a. Percentage of children who had one follow-up visit with a practitioner with prescribing authority during the 30-Day Initiation Phase. b. Percentage of children who remained on ADHD medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two additional follow-up visits with a practitioner within 270			
<input type="checkbox"/>	CMS169v2	NQF 0110	Bipolar Disorder and Major Depression: Appraisal for alcohol or chemical substance use.	Percentage of patients with depression or bipolar disorder with evidence of an initial assessment that includes an appraisal for alcohol or chemical substance use.			
<input type="checkbox"/>	CMS141v3	NQF 0385	Colon Cancer: Chemotherapy for AJCC Stage III Colon Cancer Patients.	Percentage of patients aged 18 through 80 years with AJCC Stage III colon cancer who are referred for adjuvant chemotherapy, prescribed adjuvant chemotherapy, or have previously received adjuvant chemotherapy within the 12-month reporting period.			

<input type="checkbox"/>	CMS140v2	NQF 0387	Breast Cancer: Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/Progesteron Receptor (ER/PR) Positive Breast	Percentage of female patients aged 18 years and older with Stage IC through IIIC, ER or PR positive breast cancer who were prescribed tamoxifen or aromatase inhibitor (AI) during the 12-month reporting period.			
<input type="checkbox"/>	CMS62v2	NQF 0403	HIV/AIDS: Medical Visit.	Percentage of patients, regardless of age, with a diagnosis of HIV/AIDS with at least two medical visits during the measurement year with a minimum of 90 days between each visit.			
<input type="checkbox"/>	CMS52v2	NQF 0405	HIV/AIDS: Pneumocystis jiroveci pneumonia (PCP) prophylaxis.	Percentage of patients aged 6 weeks and older with a diagnosis of HIV/AIDS who were prescribed Pneumocystis jiroveci pneumonia (PCP) prophylaxis.			
<input type="checkbox"/>	CMS2v3	NQF 0418	Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan	Percentage of patients aged 12 years and older screened for clinical depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen.			
<input type="checkbox"/>	CMS133v2	NQF 0565	Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery.	Percentage of patients aged 18 years and older with a diagnosis of uncomplicated cataract who had cataract surgery and no significant ocular conditions impacting the visual outcome of surgery and had best-corrected visual acuity of 20/40 or better (distance or near) achieved within 90 days following the cataract surgery.			
<input type="checkbox"/>	CMS158v2	NQF 0608	Pregnant women that had HBsAg testing.	This measure identifies pregnant women who had a HBsAg (hepatitis B) test during their pregnancy.			
<input type="checkbox"/>	CMS159v2	NQF 0710	Depression Remission at Twelve Months	Adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score > 9 who demonstrate remission at twelve months defined as PHQ-9 score less than 5. This measure applies to both patients with newly diagnosed and existing depression whose current PHQ-9 score indicates a need for treatment.			
<input type="checkbox"/>	CMS160v2	NQF 0712	Depression Utilization of the PHQ-9 Tool.	Adult patients age 18 and older with the diagnosis of major depression or dysthymia who have a PHQ-9 tool administered at least once during a 4-month period in which there was a qualifying visit.			
<input type="checkbox"/>	CMS149v2	<none>	Dementia: Cognitive Assessment.	Percentage of patients, regardless of age, with a diagnosis of dementia for whom an assessment of cognition is performed and the results reviewed at least once within a 12 month period.			
<input type="checkbox"/>	CMS61v3	<none>	Preventive Care and Screening: Cholesterol - Fasting Low Density Lipoprotein (LDL-C) Test Performed	Percentage of patients aged 20 through 79 years whose risk factors have been assessed and a fasting LDL-C test has been performed.			

<input type="checkbox"/>	CMS64v3	<none>	Preventive Care and Screening: Risk-Stratified Cholesterol Fasting Low Density Lipoprotein (LDL-C).	Percentage of patients aged 20 through 79 years who had a fasting LDL-C test performed and whose risk-stratified fasting LDL-C is at or below the recommended LDL-C goal.			
<input type="checkbox"/>	CMS65v3	<none>	Hypertension: Improvement in Blood Pressure.	Percentage of patients aged 18-85 years of age with a diagnosis of hypertension whose blood pressure improved during the measurement period.			
<input type="checkbox"/>	CMS74v3	<none>	Primary Caries Prevention Intervention as Offered by Primary Care Providers, including Dentists.	Percentage of children, age 0-20 years, who received a fluoride varnish application during the measurement period.			
<input type="checkbox"/>	CMS75v2	<none>	Children Who Have Dental Decay or Cavities.	Percentage of children, age 0-20 years, who have had tooth decay or cavities during the measurement period.			
<input type="checkbox"/>	CMS77v2	<none>	HIV/AIDS: RNA Control for Patients with HIV.	Percentage of patients aged 13 years and older with a diagnosis of HIV/AIDS, with at least two visits during the measurement year, with at least 90 days between each visit, whose most recent HIV RNA level is <200 copies/mL.			

Meaningful Use Wizard

Clinical Quality Measure CMS137v2 (NQF 0004)

[CMS Specification Sheet for this measure](#)

Provider: Eggplant, Debbie (NPI: 1212121212)

Mrs Req. 9

Mrs Slctd. 2

Dms Req. 3

Dms Slctd. 2

Title

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment.

Description

Percentage of patients 13 years of age and older with a new episode of alcohol and other drug (AOD) dependence who received the following.

Two rates are reported.

- a. Percentage of patients who initiated treatment within 14 days of the diagnosis.
- b. Percentage of patients who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation

Complete the following information:

Population Criteria 1

Numerator 1:	<input type="text" value="0"/>	Denominator	<input type="text" value="0"/>	Exclusion	<input type="text" value="0"/>
Numerator 2:	<input type="text" value="0"/>	Denominator	<input type="text" value="0"/>	Exclusion	<input type="text" value="0"/>

Population Criteria 2:

Numerator 1:	<input type="text" value="0"/>	Denominator	<input type="text" value="0"/>	Exclusion	<input type="text" value="0"/>
Numerator 2:	<input type="text" value="0"/>	Denominator	<input type="text" value="0"/>	Exclusion	<input type="text" value="0"/>

Meaningful Use Wizard

[CMS Specification Sheet for this measure](#)

Clinical Quality Measure CMS165v2 (NQF 0018)

Provider: Eggplant, Debbie (NPI: 1212121212)

Msrs Req. 9

Msrs Slctd. 1

Dms Req. 3

Dms Slctd. 1

Title

Controlling High Blood Pressure

Description

Percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90mmHg) during the n

Complete the following information:

Numerator:

Denominator:

Exclusion:

Meaningful Use Wizard

[CMS Specification Sheet for this measure](#)

Clinical Quality Measure CMS125v2 (NQF 0031)

Provider: Eggplant, Debbie (NPI: 1212121212)

Msrs Req. 9

Msrs Slctd. 1

Dms Req. 3

Dms Slctd. 1

Title

Breast Cancer Screening

Description

The percentage of women 40-69 years of age who had a mammogram to screen for breast cancer.

Complete the following information:

Numerator:

Denominator:

Exclusion:

Meaningful Use Wizard

[CMS Specification Sheet for this measure](#)

Clinical Quality Measure CMS124v2 (NQF 0032)

Provider: Eggplant, Debbie (NPI: 1212121212)

Msrs Req. 9

Msrs Slctd. 1

Dms Req. 3

Dms Slctd. 1

Title

Cervical Cancer Screening

Description

Percentage of women 21-64 years of age, who received one or more Pap tests to screen for cervical cancer.

Complete the following information:

Numerator:

Denominator:

Exclusion:

Meaningful Use Wizard

[CMS Specification Sheet for this measure](#)

Clinical Quality Measure CMS130v2 (NQF 0034)

Provider: Eggplant, Debbie (NPI: 1212121212)

Mrs Req. 9

Mrs Slctd. 1

Dms Req. 3

Dms Slctd. 1

Title

Colorectal Cancer Screening

Description

The percentage of adults 50-75 years of age who had appropriate screening for colorectal cancer.

Complete the following information:

Numerator:

Denominator:

Exclusion:

Meaningful Use Wizard

[CMS Specification Sheet for this measure](#)

Clinical Quality Measure CMS126v2 (NQF 0036)

Provider: Eggplant, Debbie (NPI: 1212121212)

Mrs Req. 9

Mrs Slctd. 1

Dms Req. 3

Dms Slctd. 1

Title

Use of Appropriate Medications for Asthma

Description

Percentage of patients 5-64 years of age who were identified as having persistent asthma and were appropriately prescribed medication during the measurement period.

Complete the following information:

Population Criteria 1 Numerator 1: Denominator: Exclusion:

Population Criteria 2 Numerator 2: Denominator: Exclusion:

Population Criteria 3 Numerator 3: Denominator: Exclusion:

Population Criteria 4 Numerator 4: Denominator: Exclusion:

Meaningful Use Wizard

[CMS Specification Sheet for this measure](#)

Clinical Quality Measure CMS127v2 (NQF 0043)

Provider: Eggplant, Debbie (NPI: 1212121212)

Msr Req. 9

Msr Slctd. 1

Dms Req. 3

Dms Slctd. 1

Title

Pneumonia Vaccination Status for Older Adults

Description

The percentage of patients 65 years of age and older who have ever received a pneumococcal vaccine.

Complete the following information:

Numerator:

Denominator:

Meaningful Use Wizard

[CMS Specification Sheet for this measure](#)

Clinical Quality Measure CMS131v2 (NQF 0055)

Provider: Eggplant, Debbie (NPI: 1212121212)

Msr Req. 9

Msr Slctd. 1

Dms Req. 3

Dms Slctd. 1

Title

Diabetes: Eye Exam

Description

Percentage of patients 18-75 years of age with diabetes who had a retinal or dilated eye exam by an eye care professional during the measurement period or a retinopathy) in the 12 months prior to the measurement period.

Complete the following information:

Numerator:

Denominator:

Exclusion:

Meaningful Use Wizard

[CMS Specification Sheet for this measure](#)

Clinical Quality Measure CMS123v2 (NQF 0056)

Provider: Eggplant, Debbie (NPI: 1212121212)

Msr Req. 9

Msr Slctd. 1

Dms Req. 3

Dms Slctd. 1

Title

Diabetes: Foot Exam

Description

Percentage of patients aged 18-75 years of age with diabetes who had a foot exam during the measurement period.

Complete the following information:

Numerator:

Denominator:

Exclusion:

Meaningful Use Wizard

[CMS Specification Sheet for this measure](#)

Clinical Quality Measure CMS122v2 (NQF 0059)

Provider: Eggplant, Debbie (NPI: 1212121212)

Msrs Req. 9

Msrs Slctd. 1

Dms Req. 3

Dms Slctd. 1

Title

Diabetes: HbA1c Poor Control

Description

The percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had HbA1c >9.0%.

Complete the following information:

Numerator:

Denominator:

Exclusion:

Meaningful Use Wizard

[CMS Specification Sheet for this measure](#)

Clinical Quality Measure CMS148v2 (NQF 0060)

Provider: Eggplant, Debbie (NPI: 1212121212)

Msrs Req. 9

Msrs Slctd. 1

Dms Req. 3

Dms Slctd. 1

Title

Hemoglobin A1c Test for Pediatric Patients.

Description

Percentage of patients 5-17 years of age with diabetes with an HbA1c test during the measurement period.

Complete the following information:

Numerator:

Denominator:

Exclusion:

Meaningful Use Wizard

[CMS Specification Sheet for this measure](#)

Clinical Quality Measure CMS134v2 (NQF 0062)

Provider: Eggplant, Debbie (NPI: 1212121212)

Msrs Req. 9

Msrs Slctd. 1

Dms Req. 3

Dms Slctd. 1

Title

Diabetes: Urine Protein Screening.

Description

The percentage of patients 18-75 years of age with diabetes who had a nephropathy screening test or evidence of nephropathy during the measurement period.

Complete the following information:

Numerator:

Denominator:

Exclusion:

Meaningful Use Wizard

[CMS Specification Sheet for this measure](#)

Clinical Quality Measure CMS163v2 (NQF 0064)

Provider: Eggplant, Debbie (NPI: 1212121212)

Msrs Req. 9

Msrs Slctd. 1

Dms Req. 3

Dms Slctd. 1

Title

Diabetes: Low Density Lipoprotein (LDL) Management.

Description

Percentage of patients 18-75 years of age with diabetes whose LDL-C was adequately controlled (<100 mg/dL) during the measurement period.

Complete the following information:

Numerator:

Denominator:

Exclusion:

Meaningful Use Wizard

[CMS Specification Sheet for this measure](#)

Clinical Quality Measure CMS164v2 (NQF 0068)

Provider: Eggplant, Debbie (NPI: 1212121212)

Msrs Req. 9

Msrs Slctd. 1

Dms Req. 3

Dms Slctd. 1

Title

Ischemic Vascular Disease (IVD): Use of Aspirin or another Antithrombotic

Description

Percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutar months prior to the measurement period, or who had an active diagnosis of ischemic vascular disease (IVD) during the measurement period, and who had documet antithrombotic during the measurement period.

Complete the following information:

Numerator:

Denominator:

Meaningful Use Wizard

[CMS Specification Sheet for this measure](#)

Clinical Quality Measure CMS145v2 (NQF 0070)

Provider: Eggplant, Debbie (NPI: 1212121212)

Msrs Req. 9

Msrs Slctd. 1

Dms Req. 3

Dms Slctd. 1

Title

Coronary Artery Disease (CAD): Beta-Blocker Therapy Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF <40%).

Description

Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12 month period who also have a prior MI or a current or prior LVEF <40% who were prescribed beta-blocker therapy.

Complete the following information:

Population Criteria 1

Numerator 1:

Denominator:

Exception

Population Criteria 2

Numerator 2:

Denominator

Exception

Meaningful Use Wizard

[CMS Specification Sheet for this measure](#)

Clinical Quality Measure CMS182v3 (NQF 0075)

Provider: Eggplant, Debbie (NPI: 1212121212)

Msrs Req. 9

Msrs Slctd. 1

Dms Req. 3

Dms Slctd. 1

Title

Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control.

Description

Percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) in the 12 months prior to the measurement period, or who had an active diagnosis of ischemic vascular disease (IVD) during the measurement period, and who had a complete lipid profile performed during the measurement period and whose LDL-C was adequately

Complete the following information:

Numerator 1:

Denominator:

Numerator 2:

Denominator

Meaningful Use Wizard

[CMS Specification Sheet for this measure](#)

Clinical Quality Measure CMS135v2 (NQF 0081)

Provider: Eggplant, Debbie (NPI: 1212121212)

Msrs Req. 9

Msrs Slctd. 1

Dms Req. 3

Dms Slctd. 1

Title

Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)

Description

Percentage of patients aged 18 years and older with a diagnosis of heart failure (HF) with a current or prior left ventricular ejection fraction (LVEF) < 40% who were either within a 12 month period when seen in the outpatient setting OR at each hospital discharge.

Complete the following information:

Numerator:

Denominator:

Exception:

Meaningful Use Wizard

[CMS Specification Sheet for this measure](#)

Clinical Quality Measure CMS144v2 (NQF 0083)

Provider: Eggplant, Debbie (NPI: 1212121212)

Msrs Req. 9

Msrs Slctd. 1

Dms Req. 3

Dms Slctd. 1

Title

Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD).

Description

Percentage of patients aged 18 years and older with a diagnosis of heart failure (HF) with a current or prior left ventricular ejection fraction (LVEF) < 40% who were within a 12 month period when seen in the outpatient setting OR at each hospital discharge.

Complete the following information:

Numerator:

Denominator:

Exception:

Meaningful Use Wizard

[CMS Specification Sheet for this measure](#)

Clinical Quality Measure CMS143v2 (NQF 0086)

Provider: Eggplant, Debbie (NPI: 1212121212)

Msrs Req. 9

Msrs Slctd. 1

Dms Req. 3

Dms Slctd. 1

Title

Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation

Description

Percentage of patients aged 18 years and older with a diagnosis of primary open-angle glaucoma (POAG) who have an optic nerve head evaluation during one or

Complete the following information:

Numerator:

Denominator:

Exception:

Meaningful Use Wizard

[CMS Specification Sheet for this measure](#)

Clinical Quality Measure CMS167v2 (NQF 0088)

Provider: Eggplant, Debbie (NPI: 1212121212)

Msrs Req. 9

Msrs Slctd. 1

Dms Req. 3

Dms Slctd. 1

Title

Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy

Description

Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed which included docu retinopathy and the presence or absence of macular edema during one or more office visits within 12 months.

Complete the following information:

Numerator:

Denominator:

Exception:

Meaningful Use Wizard

[CMS Specification Sheet for this measure](#)

Clinical Quality Measure CMS142v2 (NQF 0089)

Provider: Eggplant, Debbie (NPI: 1212121212)

Msrs Req. 9

Msrs Slctd. 1

Dms Req. 3

Dms Slctd. 1

Title

Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care

Description

Percentage of patients aged 18 through 80 years with AJCC Stage III colon cancer who are referred for adjuvant chemotherapy, prescribed adjuvant chemotherapy, chemotherapy within the 12-month reporting period.

Complete the following information:

Numerator:

Denominator:

Exception:

Meaningful Use Wizard

[CMS Specification Sheet for this measure](#)

Clinical Quality Measure CMS161v2 (NQF 0104)

Provider: Eggplant, Debbie (NPI: 1212121212)

Msrs Req. 9

Msrs Slctd. 1

Dms Req. 3

Dms Slctd. 1

Title

Adult Major Depressive Disorder (MDD): Suicide Risk Assessment.

Description

Percentage of patients aged 18 years and older with a diagnosis of major depressive disorder (MDD) with a suicide risk assessment completed during the visit in w was identified.

Complete the following information:

Numerator:

Denominator:

[CMS Specification Sheet for this measure](#)

Meaningful Use Wizard

Clinical Quality Measure CMS128v2 (NQF 0105)

Provider: Eggplant, Debbie (NPI: 1212121212)

Msrs Req. 9

Msrs Slctd. 1

Dms Req. 3

Dms Slctd. 1

Title

Anti-depressant Medication Management.

Description

Percentage of patients 18 years of age and older who were diagnosed with major depression and treated medication, and who remained on antidepressant medication treatment.

Two rates are reported.

- a. Percentage of patients who remained on an antidepressant medication for at least 84 days (12 weeks).
- b. Percentage of patients who remained on an antidepressant medication for at least 180 days (6 months).

Complete the following information:

Numerator 1: Denominator: Exclusion:

Numerator 2: Denominator: Exclusion:

Meaningful Use Wizard

[CMS Specification Sheet for this measure](#)

Clinical Quality Measure CMS136v3 (NQF 0108)

Provider: Eggplant, Debbie (NPI: 1212121212)

Msrs Req. 9

Msrs Slctd. 1

Dms Req. 3

Dms Slctd. 1

Title

ADHD: Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication.

Description

Percentage of children 6-12 years of age and newly dispensed a medication for attention-deficit/hyperactivity disorder (ADHD) who had appropriate follow-up care.

Two rates are reported.

a. Percentage of children who had one follow-up visit with a practitioner with prescribing authority during the 30-Day Initiation Phase.

b. Percentage of children who remained on ADHD medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least

Complete the following information:

Numerator 1: Denominator: Exclusion:

Numerator 2: Denominator: Exclusion:

Meaningful Use Wizard

[CMS Specification Sheet for this measure](#)

Clinical Quality Measure CMS169v2 (NQF 0110)

Provider: Eggplant, Debbie (NPI: 1212121212)

Msrs Req. 9

Msrs Slctd. 1

Dms Req. 3

Dms Slctd. 1

Title

Bipolar Disorder and Major Depression: Appraisal for alcohol or chemical substance use.

Description

Percentage of patients with depression or bipolar disorder with evidence of an initial assessment that includes an appraisal for alcohol or chemical substance use.

Complete the following information:

Numerator:

Denominator:

Meaningful Use Wizard

[CMS Specification Sheet for this measure](#)

Clinical Quality Measure CMS169v2 (NQF 0110)

Provider: Eggplant, Debbie (NPI: 1212121212)

Msrs Req. 9

Msrs Slctd. 2

Dms Req. 3

Dms Slctd. 1

Title

Bipolar Disorder and Major Depression: Appraisal for alcohol or chemical substance use.

Description

Percentage of patients with depression or bipolar disorder with evidence of an initial assessment that includes an appraisal for alcohol or chemical substance use.

Complete the following information:

Numerator:

Denominator:

Meaningful Use Wizard

[CMS Specification Sheet for this measure](#)

Clinical Quality Measure CMS140v2 (NQF 0387)

Provider: Eggplant, Debbie (NPI: 1212121212)

Msrs Req. 9

Msrs Slctd. 1

Dms Req. 3

Dms Slctd. 1

Title

Breast Cancer: Hormonal Therapy for Stage IC-IIIc Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer.

Description

Percentage of female patients aged 18 years and older with Stage IC through IIIc, ER or PR positive breast cancer who were prescribed tamoxifen or aromatase in period.

Complete the following information:

Numerator:

Denominator:

Exception:

Meaningful Use Wizard

[CMS Specification Sheet for this measure](#)

Clinical Quality Measure CMS62v2 (NQF 0403)

Provider: Eggplant, Debbie (NPI: 1212121212)

Msrs Req. 9

Msrs Slctd. 1

Dms Req. 3

Dms Slctd. 1

Title

HIV/AIDS: Medical Visit.

Description

Percentage of patients, regardless of age, with a diagnosis of HIV/AIDS with at least two medical visits during the measurement year with a minimum of 90 days bet

Complete the following information:

Numerator:

Denominator:

Meaningful Use Wizard[CMS Specification Sheet for this measure](#)

Clinical Quality Measure CMS52v2 (NQF 0405)

Provider: Eggplant, Debbie (NPI: 1212121212)

Mhrs Req. 9

Mhrs Slctd. 2

Dms Req. 3

Dms Slctd. 1

Title

HIV/AIDS: Pneumocystis jiroveci pneumonia (PCP) prophylaxis.

Description

Percentage of patients aged 6 weeks and older with a diagnosis of HIV/AIDS who were prescribed Pneumocystis jiroveci pneumonia (PCP) prophylaxis.

Complete the following information:

Population Criteria 1 Numerator 1: Denominator: Exception

Population Criteria 2 Numerator 2: Denominator Exception

Population Criteria 3 Numerator 3: Denominator

Meaningful Use Wizard[CMS Specification Sheet for this measure](#)

Clinical Quality Measure CMS2v3 (NQF 0418)

Provider: Eggplant, Debbie (NPI: 1212121212)

Mhrs Req. 9

Mhrs Slctd. 3

Dms Req. 3

Dms Slctd. 1

Title

Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan

Description

Percentage of patients aged 12 years and older screened for clinical depression on the date of the encounter using an age appropriate standardized depression screen is documented on the date of the positive screen.

Complete the following information:

Numerator: Denominator: Exclusion: Exception:

Meaningful Use Wizard

[CMS Specification Sheet for this measure](#)

Clinical Quality Measure CMS133v2 (NQF 0565)

Provider: Eggplant, Debbie (NPI: 1212121212)

Msrs Req. 9

Msrs Slctd. 7

Dms Req. 3

Dms Slctd. 3

Title

Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery.

Description

Percentage of patients aged 18 years and older with a diagnosis of uncomplicated cataract who had cataract surgery and no significant ocular conditions impact best-corrected visual acuity of 20/40 or better (distance or near) achieved within 90 days following the cataract surgery.

Complete the following information:

Numerator:

Denominator:

Exclusion:

Meaningful Use Wizard

[CMS Specification Sheet for this measure](#)

Clinical Quality Measure CMS158v2 (NQF 0608)

Provider: Eggplant, Debbie (NPI: 1212121212)

Msrs Req. 9

Msrs Slctd. 8

Dms Req. 3

Dms Slctd. 3

Title

Pregnant women that had HBsAg testing.

Description

This measure identifies pregnant women who had a HBsAg (hepatitis B) test during their pregnancy.

Complete the following information:

Numerator:

Denominator:

Exception:

Meaningful Use Wizard

[CMS Specification Sheet for this measure](#)

Clinical Quality Measure CMS159v2 (NQF 0710)

Provider: Eggplant, Debbie (NPI: 1212121212)

Mrs Req. 9

Mrs Slctd. 9

Dms Req. 3

Dms Slctd. 3



Title

Depression Remission at Twelve Months

Description

Adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score > 9 who demonstrate remission at twelve months defined as PHQ-9 both patients with newly diagnosed and existing depression whose current PHQ-9 score indicates a need for treatment.

Complete the following information:

Numerator:

Denominator:

Exclusion:

Meaningful Use Wizard

[CMS Specification Sheet for this measure](#)

Clinical Quality Measure CMS160v2 (NQF 0712)

Provider: Eggplant, Debbie (NPI: 1212121212)

Mrs Req. 9

Mrs Slctd. 10

Dms Req. 3

Dms Slctd. 3

Title

Depression Utilization of the PHQ-9 Tool.

Description

Adult patients age 18 and older with the diagnosis of major depression or dysthymia who have a PHQ-9 tool administered at least once during a 4-month period in which there was a qualifying visit.

Complete the following information:

Population Criteria 1 Numerator 1: Denominator: Exclusion:

Population Criteria 2 Numerator 2: Denominator: Exclusion:

Population Criteria 3 Numerator 3: Denominator: Exclusion:

Meaningful Use Wizard

[CMS Specification Sheet for this measure](#)

Clinical Quality Measure CMS149v2 (No NQF code assigned to this measure)

Provider: Eggplant, Debbie (NPI: 1212121212)

Msrs Req. 9

Msrs Slctd. 11

Dms Req. 3

Dms Slctd. 3



Title

Dementia: Cognitive Assessment.

Description

Percentage of patients, regardless of age, with a diagnosis of dementia for whom an assessment of cognition is performed and the results reviewed at least once wi

Complete the following information:

Numerator:

Denominator:

Exclusion:

Meaningful Use Wizard

[CMS Specification Sheet for this measure](#)

Clinical Quality Measure CMS61v3 (No NQF code assigned to this measure)

Provider: Eggplant, Debbie (NPI: 1212121212)

Msrs Req. 9

Msrs Slctd. 17

Dms Req. 3

Dms Slctd. 3



Title

Preventive Care and Screening: Cholesterol - Fasting Low Density Lipoprotein (LDL-C) Test Performed.

Description

Percentage of patients aged 20 through 79 years whose risk factors have been assessed and a fasting LDL-C test has been performed.

Complete the following information:

Population Criteria 1 Numerator 1: Denominator: Exclusion: Exception:

Population Criteria 2 Numerator 2: Denominator: Exclusion: Exception:

Population Criteria 3 Numerator 3: Denominator: Exclusion: Exception:

Meaningful Use Wizard

[CMS Specification Sheet for this measure](#)

Clinical Quality Measure CMS64v3 (No NQF code assigned to this measure)

Provider: Eggplant, Debbie (NPI: 1212121212)

Mrs Req. 9

Mrs Slctd. 17

Dms Req. 3

Dms Slctd. 3



Title

Preventive Care and Screening: Risk-Stratified Cholesterol Fasting Low Density Lipoprotein (LDL-C).

Description

Percentage of patients aged 20 through 79 years who had a fasting LDL-C test performed and whose risk-stratified fasting LDL-C is at or below the recommended LDL-C goal.

Complete the following information:

Population Criteria 1 Numerator 1: 10 Denominator: 10 Exclusion 0

Population Criteria 2 Numerator 2: 10 Denominator: 10 Exclusion 0

Population Criteria 3 Numerator 3: 10 Denominator: 10 Exclusion 0

Meaningful Use Wizard

[CMS Specification Sheet for this measure](#)

Clinical Quality Measure CMS65v3 (No NQF code assigned to this measure)

Provider: Eggplant, Debbie (NPI: 1212121212)

Mrs Req. 9

Mrs Slctd. 17

Dms Req. 3

Dms Slctd. 3



Title

Hypertension: Improvement in Blood Pressure.

Description

Percentage of patients aged 18-85 years of age with a diagnosis of hypertension whose blood pressure improved during the measurement period.

Complete the following information:

Numerator: 10

Denominator: 10

Exclusion: 0

Meaningful Use Wizard

[CMS Specification Sheet for this measure](#)

Clinical Quality Measure CMS74v3 (No NQF code assigned to this measure)

Provider: Eggplant, Debbie (NPI: 1212121212)

Mrs Req. 9

Mrs Slctd. 17

Dms Req. 3

Dms Slctd. 3



Title

Primary Caries Prevention Intervention as Offered by Primary Care Providers, including Dentists.

Description

Percentage of children, age 0-20 years, who received a fluoride varnish application during the measurement period.

Complete the following information:

Ages 0-5

Numerator 1:

Denominator:

Ages 6-12

Numerator 2:

Denominator

Ages 13-20

Numerator 3:

Denominator

Meaningful Use Wizard

[CMS Specification Sheet for this measure](#)

Clinical Quality Measure CMS75v2 (No NQF code assigned to this measure)

Provider: Eggplant, Debbie (NPI: 1212121212)

Mrs Req. 9

Mrs Slctd. 17

Dms Req. 3

Dms Slctd. 3



Title

Children Who Have Dental Decay or Cavities.

Description

Percentage of children, age 0-20 years, who have had tooth decay or cavities during the measurement period.

Complete the following information:

Numerator:

Denominator:

Meaningful Use Wizard

[CMS Specification Sheet for this measure](#)

Clinical Quality Measure CMS77v2 (No NQF code assigned to this measure)

Provider: Eggplant, Debbie (NPI: 1212121212)

Mrs Req. 9

Mrs Slctd. 17

Dms Req. 3

Dms Slctd. 3



Title

HIV/AIDS: RNA Control for Patients with HIV.

Description

Percentage of patients aged 13 years and older with a diagnosis of HIV/AIDS, with at least two visits during the measurement year, with at least 90 days between e is <200 copies/mL.

Complete the following information:

Numerator:

Denominator:

C3d2d. Measure Summary Screens

C3d2d1. CQMs listed by domain

Clinical Quality Measures

Clinical Quality Measures Section

Provider: Eggplant, Debbie (NPI: 1212121212)

Clinical Quality Measure Summary.



EPs must report on 9 of the 64 approved CQMs selected from at least 3 Domains.

<i>Domain</i>	<i>Number of Measures</i>
<i>Patient and Family Engagement.</i>	4
<i>Patient Safety.</i>	6
<i>Care Coordination.</i>	1
<i>Population and Public Health.</i>	8
<i>Efficient Use of Healthcare Resources.</i>	4
<i>Clinical Processes/Effectiveness.</i>	41

Congratulations. You have selected at least 9 measures from at least 3 domains. Please select the 'Next' button to review your Core, Menu, and Clinical Quality Measure selections.

Select F3 for Jaws Screen Reader Help

< Back Next > Cancel

C3d2d2. Core Measure Summary

Maine Meaningful Use Wizard

Meaningful Use Wizard

Provider: Eggplant, Debbie (NPI: 1212121212)

Core Measures Summary

Provider Information

Name: Eggplant, Debbie
NPI: 1212121212

Core Measures

Core Measure 1

Measure Code: [EPCMU 01](#)

Pass/Fail:

Objective: *Use computerized provider order entry (CPOE) for medication, laboratory and radiology orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines.*

Entries for Core Measure 1

Measure: More than 60 percent of medication orders created by the EP during the EHR reporting period are recorded using CPOE.

Exclusion: Any EP who writes fewer than 100 medication orders during the EHR reporting period. N

Numerator: The number of medication orders in the denominator recorded using CPOE. 1

Maine OIT strongly suggests you save your settings to a file.

Save to File Print View in Browser

Select F3 for Jaws Screen Reader Help

< Back Next > Cancel

C3d2d3. Menu Measure Summary

Meaningful Use Wizard

Provider: Eggplant, Debbie (NPI: 12121212)

Menu Measures Summary

Provider Information

Name: Eggplant, Debbie
NPI: 12121212

Menu Measures

Menu Measure 3

Measure Code: [EPMU 03](#)

Pass/Fail: 

Objective: *Imaging results consisting of the image itself and any explanation or other accompanying information are accessible through CEHRT.*

Measure: *More than 10 percent of all tests whose result is one or more images ordered by the EP during the EHR reporting period are accessible through CEHRT.*

Entries for Menu Measure 3

Exclusion One: Any EP who orders less than 100 tests whose result is an image during the EHR reporting period; or any EP who has no access to electronic imaging results at the start of the EHR reporting period. Does this exclusion apply to you? N

Maine OIT strongly suggests you save your settings to a file.

Save to File Print View in Browser

Select F3 for Jaws Screen Reader Help

< Back Next > Cancel

C3d2d4. CQM Measure Summary

Meaningful Use Wizard

Provider: Eggplant, Debbie (NPI: 12121212)

Clinical Quality Measures Summary

Provider Information

Name: Eggplant, Debbie
NPI: 12121212

Clinical Quality Measures

Measure	Description	Values		
Patient and Family Engagement Domain				
(CMS157v2)	Percentage of patient visits, regardless of patient age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy in which pain intensity is quantified.	Submeasure 1		
		<i>Numerator</i>	<i>Denominator</i>	
		10	10	
(CMS56v2)	Percentage of patients aged 18 years and older with primary total hip arthroplasty (THA) who completed baseline and follow-up (patient-reported) functional status assessments.	Submeasure 1		
		<i>Numerator</i>	<i>Denominator</i>	<i>Exclusion</i>
		10	10	0
	Percentage of patients aged 18 years and older with primary	Submeasure 1		

Maine OIT strongly suggests you save your settings to a file.

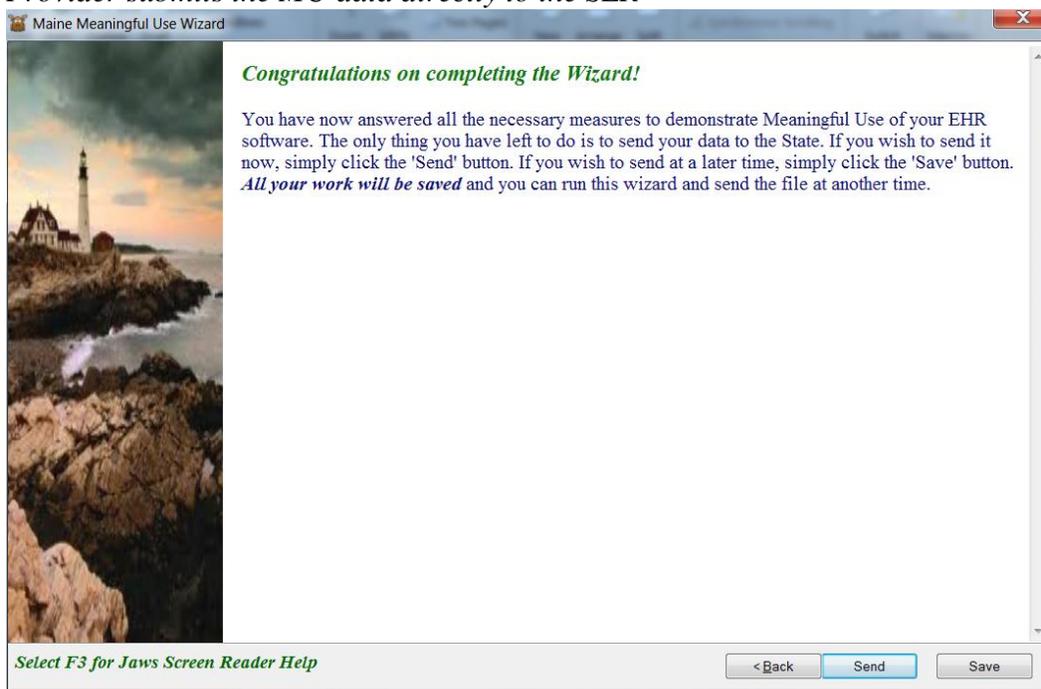
Save to File Print View in Browser

Select F3 for Jaws Screen Reader Help

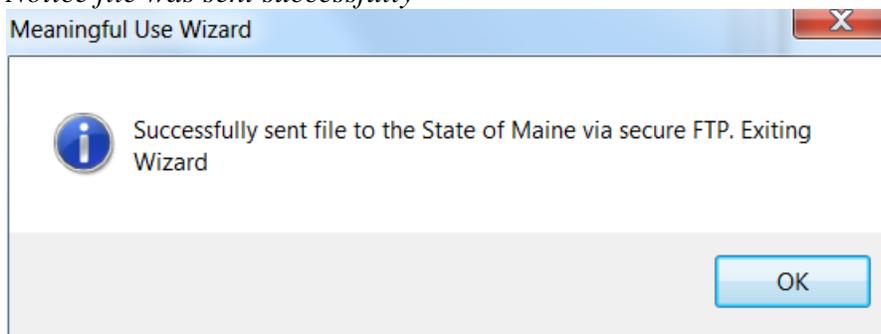
< Back Next Cancel

C3d2e.Completion Screen

Provider submits the MU data directly to the SLR



Notice file was sent successfully



C3d2f. SLR/HIT Specialist actions for review of submitted MU attestations

- The provider's MU data is submitted directly to Maine's SLR from the wizard application.
- The HIT specialist receives notification of the submission via email; if multiple providers were submitted from that wizard application they would be listed in one notice:

-----Original Message-----

From: (UAT) HIT Notification [<mailto:DO-NOT-REPLY@maine.gov>]

Sent: Tuesday, November 10, 2015 1:24 PM

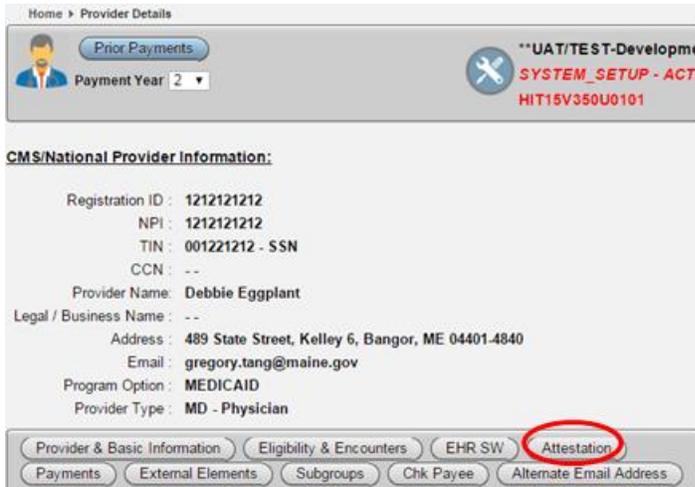
To: Tang, Gregory

Subject: (UAT/TEST)**INBOUND** (C5) – NLR to MAINE EHR/HIT Hospital Attestation File Complete

1 record(s) updated via NLR attestation file EPC5_1212121212_7089436c-7198-41ea-be9f-73aa161a4efb.xml on 11/10/2015

REGID:1212121212 – NPI:1212121212 – Eggplant, Debbie - gregory.tang@maine.gov – XYZ Family Practice

- The HIT specialist goes into the provider’s record in the SLR; selects the attestation button



- The MU file is imported by core, menu and CQM data (all submissions prior to 2015)
- The HIT specialist selects the Approve MU Attestation button



- All of the submitted MU data is presented for the HIT specialist to review

② MU - View CORE Measures

Status	Category	User	Objective ID	Objective Name	Mtr #	Mtr Desc	T/F	Num	Denom	Calc Pct	Tot Pct	Diff	Excl 1 #	Excl 2 #	Excl 3 #	Excl 4 #	Compliance	User	Reason	SubMtrID
CORE	ADMIN	ADMIN	EPCMU 01	CPOE for Medication, Laboratory and Radiology Orders	1	Measure 1/3: "MEDICATION" -- More than 60 percent of medication orders created by the EP during the EHR reporting period are recorded using CPOE.		111	111	100.0000	60	40.00	N					ADMIN		0000120676
CORE	ADMIN	ADMIN	EPCMU 01	CPOE for Medication, Laboratory and Radiology Orders	2	Measure 2/3: "RADIOLOGY" -- More than 30 percent of radiology orders created by the EP during the EHR reporting period are recorded using CPOE.					30		Y					ADMIN		0000120677
CORE	ADMIN	ADMIN	EPCMU 01	CPOE for Medication, Laboratory and Radiology Orders	3	Measure 3/3: "LABORATORY" -- More than 30 percent of laboratory orders created by the EP during the EHR reporting period are recorded using CPOE.					30		Y					ADMIN		0000120678
CORE	ADMIN	ADMIN	EPCMU 02	e-Prescribing (eRx)	1	More than 50 percent of all permissible prescriptions, or all prescriptions, written by the EP are queried for a drug formulary and transmitted electronically using CEHRT.		111	111	100.0000	50	50.00	N	N				ADMIN		0000120679
CORE	ADMIN	ADMIN	EPCMU 03	Record a specific set of demographics	1	More than 60 percent of all unique patients seen by the EP have demographics recorded as structured data.		22	22	100.0000	80	20.00						ADMIN		0000120680
CORE	ADMIN	ADMIN	EPCMU 04	Record and chart changes for specific vital signs	1	More than 60 percent of all unique patients seen by the EP have blood pressure (for patients age 3 and over only) and/or height and weight (for all ages) recorded as structured data.		333	333	100.0000	80	20.00	N	N	N	N		ADMIN		0000120681
CORE	ADMIN	ADMIN	EPCMU 05	Record smoking status for patients 13 years old or older	1	More than 60 percent of all unique patients 13 years old or older seen by the EP have smoking status recorded as structured data.		44	44	100.0000	80	20.00	N					ADMIN		0000120682
CORE	ADMIN	ADMIN	EPCMU 06	Clinical Decision Support Rule	1	Measure 1: Implement five clinical decision support interventions related to four or more clinical quality measures at a relevant point in patient care for the entire EHR reporting period. Absent four clinical quality measures related to an EP's scope of practice or patient population, the clinical decision support interventions must be related to high-priority health conditions.							Y					ADMIN		0000120683
CORE	ADMIN	ADMIN	EPCMU 06	Clinical Decision Support Rule	2	Measure 2: The EP has enabled and implemented the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period.								N				ADMIN		0000120684
CORE	ADMIN	ADMIN	EPCMU 07	Patient Electronic Access	1	Measure 1: More than 50 pct of all unique patients seen by the EP during the EHR rpt period are provided timely (available to the patient within 4 bizdays after the information is available to the EP) online access to their health information.		55	55	100.0000	50	50.00						ADMIN		0000120685
CORE	ADMIN	ADMIN	EPCMU 07	Patient Electronic Access	2	Measure 2: More than 5 percent of all unique patients seen by the EP during the EHR reporting period (or their authorized representatives) view, download, or transmit to a third party their health information.		55	55	100.0000	5	95.00	N	N				ADMIN		0000120686
CORE	ADMIN	ADMIN	EPCMU 08	Provide clinical summaries for patients for each office visit	1	Clinical summaries provided to patients or patient-authorized representatives within one business day for more than 50 percent of office visits.		66	66	100.0000	50	50.00	N					ADMIN		0000120687
CORE	ADMIN	ADMIN	EPCMU 09	Protect Electronic Health Information	1	Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a) (1), including addressing the encryption/security of data stored in CEHRT in accordance with requirements under 45 CFR 164.312 (a)(2)(iv) and 45 CFR 164.308(a)(3), and implement security updates as necessary and correct identified security deficiencies as part of the provider's risk management process for EPs.							Y					ADMIN		0000120688
CORE	ADMIN	ADMIN	EPCMU 10	Incorporate clinical lab-test results into EHR as structured data	1	More than 55 percent of all clinical lab tests results ordered by the EP during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in Certified EHR Technology as structured data.		6	6	100.0000	55	45.00	N					ADMIN		0000120689
CORE	ADMIN	ADMIN	EPCMU 11	Generate lists of patients by specific conditions	1	Generate at least one report listing patients of the EP with a specific condition.							Y					ADMIN		0000120690

- The HIT specialist reviews the submitted data
- If any corrections are required the HIT specialist contacts the provider to resubmit the MU data
- If the submissions is correct the HIT specialist selects the Approve All Attestations button

CQM ADMIN NQF CMS90 Functional Status Assessment for Complex Chronic Conditions.

Back Print

Approve ALL Attestations

Confirmation Screen

- The HIT specialist selects the Confirm Attestations are completed button

EHR Registration ID: 1212121212
NPI: 1212121212

Provider Name: Debbie Eggplant
Legal Name: -
Email: gregory.tang@maine.gov
Phone: (207) 545-3900

Mark ALL MEANINGFUL USE Categories, Objectives and Measures as ATTESTED?

NOTE: You cannot EDIT Status or Measure Details once you Attest MU as COMPLETE

Submission Date	Ehr Rpt Sdate	Ehr Rpt Edate	Attestation Category	Cat Compliance Status	Cat Compliance User
11/02/2015	01/01/2014	12/31/2014	MEANINGFUL_USE_CORE_MEASURES	ADMIN	ADMIN
11/02/2015	01/01/2014	12/31/2014	MEANINGFUL_USE_MENU_MEASURES	ADMIN	ADMIN
11/02/2015	01/01/2014	12/31/2014	CORE_CLINICAL_QUALITY_MEASURES	ADMIN	ADMIN

<< Back **Confirm Attestations are COMPLETED**

- The SLR is updated after the HIT specialist has approved the MU submission

Attestation page updated

MU Source **Wizard**
 MU EPC5 Filename **EPC5_12121212_7089436c-7198-41ea-be9f-73aa161a4efb.xml**
 MU Src Provider Name **Eggplant, Debbie**
 MU Wizard Version **EP Wizard 3.36.5599.26008 MU Year 2014 Stage 2**



NOTE: The Submitted MU Measures have been APPROVED and cannot be edited.
 You may review the details but no changes can be made or saved.

MU Category	Attest ID	Submitted On	MU START Date	MU END Date	Attest CAT ID	Status	Reason	User
MEANINGFUL_USE_CORE_MEASURES	000006025	11/02/2015	01/01/2014	12/31/2014	0000011002	COMPLETE	-	PATTY
MEANINGFUL_USE_MENU_MEASURES	000006025	11/02/2015	01/01/2014	12/31/2014	0000011003	COMPLETE	-	PATTY
CORE_CLINICAL_QUALITY_MEASURES	000006025	11/02/2015	01/01/2014	12/31/2014	0000011004	COMPLETE	-	PATTY

[View MU Attestation Summary](#)

Summary page updated

Home > Provider Details > Summary

REGID 1212121212 NPI 1212121212 TIN 001221212 - 55N CCN - Program MEDICAID Type MD - Physician Is a Hospital? N MHMS Provider# 1111111111 MHMS Group# - MHMS Location - Licensed No Sanctions Y Active	Provider Eggplant, Debbie Address 489 State Street, Kelley 6, Bangor, ME 04401-4840 E-mail gregory.tang@maine.gov Phone (207) 945-3800 Payee Provider XYZ Family Practic, FirstX MiddleX LastX Payee NPI 1796789147 Payee TIN 010211501 - EIN Payee Address 123 Hospital Lane, Augusta, ME 04333 Payee Email xyz@maine.org Payment Year 2	EHR Centum 1314E01PE6AWEAR SLR Centum - Hospital Based N Is Pediatrician N FQHC/RHC Based N Total Medicaid Encounters 444 Total Encounters 1111 Pct Medicaid Encounters 39.96
---	---	--

Transaction Type ADD
 Transaction Date 11-SEP-2015 05:01AM
 Transaction Num 9869619-0000003

① NLR LOG RPT (All Processes / All PYs)
 ② NLR B6 Historical Details (All PYs)

Eligibility Status	Checkpoint Basic Information	Checkpoint Types/Encounters	Checkpoint EHR SW	Checkpoint Attestation
Status ELIGIBLE Appl Sent 10.NOV.2015 01:16PM Appl Rcvd 10.NOV.2015 12:00AM Elg Date 10.NOV.2015 01:17PM Elg User GTANG Send B7 Y	Passed Y Date 10.NOV.2015 01:17PM User GTANG PY2+ Appl USER GTANG Prntsk -	User GTANG Passed Y Date 10.NOV.2015 01:18PM	User GTANG Passed Y Date 10.NOV.2015 01:19PM MU Start 01/01/2014 MU End 12/31/2014 Calc'd Period 365 MU Program Yr 2014 MU Stage 2 Mu Period 365 Mu Iteration 1	Passed (S,AIU) - Attest Sent - Attest Rcvd - User - Aiu Type M MU Src Wizard MU Src Filename EPC5_12121212_7089436c-7198-41ea-be9f-73aa161a4efb.xml MU Src Provider Eggplant, Debbie MU Src Version EP Wizard 3.36.5599.26008 MU Year 2014 Stage 2

After the approval of submitted MU the process continues to the attestation statement. The workflow processes for an AIU or MU submission are rejoined at this step.

C3d2g. Attestation Statement

After a provider's application for AIU or MU has been accepted the provider is sent the attestation statement by the HIT specialist.



Figure 70 - Attestation

The attestation page contains a summary of all submitted information as well as the attestation statement the SLR will send to the provider via email.

- The HIT specialist reviews all information: Provider detail, Payee information, attesting to: AIU or MU, confirmation CEHRT is 2014 compliant.

Home > Provider Details >

REGID 1212121212
 NPI 1212121212
 TIN [Redacted]
 Address [Redacted]
 Provider Name Debbie Eggplant
 Legal Name -
 Email gregory.tang@maine.gov
 Phone [Redacted]

No data found for provider Specialty

Attesting to: AIU (ADOPTED)

Payee Information Applicable Only if Reassigning Payment

Payee Name
 Npi [Redacted]
 Tin [Redacted]
 Email xyz@maine.org
 Phone (207) 111-1111
 Name XYZ Family Practic
 Address 123 Hospital Lane, Augusta, ME 04333

Encounter Rpt Sdate 04/01/2015
 Encounter Rpt Edate 06/29/2015
 Total Medicaid Encounters -
 Total Encounters 697
 Pct Medicaid Encounters 60.4
 Needy Encounters 421

Attests to the following Provider/Practice Details:

EHR Payment Year: 1
 EHR SW Vendor: athenahealth, Inc
 EHR SW Version: 14.1
 EHR CERTNUM 1314E01PE0AWEAR
 EHR Certification Year/Year Compliant to 2014
 EHR CHPL #: 140056R06

Figure 71 - Attestation page in SLR

- The HIT specialist verifies the application program year based on information from the provider as well as information from the NLR to the SLR via the B6 log

SLR Timestamp	NLR Timestamp	PY	Source	Action	Shd/Rcv	Filename	Transaction#	FC#	NLR Comment	SLR Comment
09/28/2015	09/11/2015	1	B6	ADD	RCV	P#EFT.ON.NME.REGS4ST.D141211.T0101368	9869619-0000003	9869619	9869619	B6 - ADD - 1212121212 - Eggplant, Debbie (ME)

Figure 72 - Attestation page in SLR; B6 log

- HIT specialist selects the application program year (AIU application; this step is done previously for a MU submission)

General Details

Enter the Application Program Year (expected for Payment) 2015

-Select-
 2011
 2012
 2013
 2014
 2015
 2016
 2017
 2018
 2019
 2020
 2021

Figure 73 - Attestation page in SLR: Application program year

- HIT specialist records the Medicare adjustment detail if submitted on the worksheet

MEDICARE Adjustment Details [optional]

Are they a CANDIDATE for the Adjustment? YES (w-Provider Type: MD)

Did they Recieve a HardshipHardship Exemption? N/A

If YES to a Hardship Exemption or Disqualified -Select-

Enter the MADJ Year -Select-

Figure 74 - Attestation page in SLR: Medicare Payment Adjustment

- HIT specialist sends the attestation email from the SLR



Figure 75 - Attestation page in SLR: Send attestation email

- HIT specialist confirms the attestation is sent for the correct provider and to the correct email then selects the Next/Send Attestation button.

Home > Provider Details > Attestation > Email Attestation

Please verify that this is the Provider you wish to e-mail an Attestation Statement for Signature

Email this Provider an Attestation Statement?

PROVIDER Debbie Eggplant
 NPI 1212121212
 TIN [REDACTED]
 CCN [REDACTED]
 ADDRESS [REDACTED]
 PAYEE_ADDRESS 123 Hospital Lane, Augusta, ME 04333
 Phone [REDACTED]

This email will be sent to >> patricia.chubbuck@maine.gov <<
 For Provider >> Debbie Eggplant << (REGID:1212121212/NPI:1212121212)

ALERT: An ALTERNATE/SECONDARY Email is being used. The original email is >> gregory.tang@maine.gov <<

Note: If you have e-mailed the Provider an Attestation Statement, selecting the 'Sent Email Manually' button will update the database using the current date and time as the date the attestation was sent.

<< Back
 Sent Email Manually **Next / SEND Attestation>>**

Figure 76 - Attestation page in SLR: Send attestation email

- All actions performed by the HIT specialist are recorded on the summary page. Note the attest sent date and time stamp.
- The summary page shows the progress the provider has made through the process.

Home > Provider Details > Summary

REGID 1212121212	Provider Eggplant, Debbie	EHR Certnum 1314E01PE0AWEAR
NPI 1212121212	Address [REDACTED]	SLR Certnum 1314E01QEXWMEAX
TIN [REDACTED]	E-mail gregory.tang@maine.gov	Hospital Based N
CCN -	Phone [REDACTED]	Is Pediatrician N
Program MEDICAID	Payee Provider XYZ Family Practic	FQHC/RHC Based Y
Type MD - Physician	Payee NPI [REDACTED]	Total Medicaid Encounters -
Is a Hospital? N	Payee TIN [REDACTED]	Total Encounters 697
MIHMS Provider# 1111111111	Payee Address 123 Hospital Lane, Augusta, ME 04333	Pct Medicaid Encounters 60.40
MIHMS Group# -	Payee Email xyz@maine.org	
MIHMS Location -	Payment Year 1	
Licensed No Sanctions Y		Transaction Type ADD
Active		Transaction Date 11-SEP-2015 01:01AM
		Transaction Num 9869619.0000003

NLR LOG RPT (All Processes / All PYs)
 NLR B6 Historical Details (All PYs)

Eligibility Status	Checkpoint Basic Information	Checkpoint Types/Encounters	Checkpoint EHR SW	Checkpoint Attestation
Status ELIGIBLE	Passed Y	User PATTY	User PATTY	Passed (S. All)
Appl Sent 28-SEP-2015 01:26PM	Date 04-NOV-2015 05:32PM	Passed Y	Passed Y	Attest Sent 05-NOV-2015 05:03PM
Appl Rcvd 04-NOV-2015 12:00AM	User PATTY	Date 05-NOV-2015 12:24PM	Date 05-NOV-2015 01:25PM	Attest Rcvd -
Elig Date 04-NOV-2015 05:32PM	PY2+ Appl USER	----	----	User -
Elig User PATTY	Preisk -	MU Email User -	MU Start -	Attest Type A
Send Y		MU Email Sent -	MU End -	MU Src -
B7		MU C5 Rcvd -	Calc'd Period -	MU Src Filename -
		MU Approved N/A - PY1	Program Yr -	MU Src Provider -
			MU Stage -	MU Src Version -
			Mu Period -	
			Mu Iteration -	

Figure 77 - Attestation page in SLR: Summary page in SLR

The email is sent to the address supplied in the registration. The provider (or their representative)

will sign (electronically) and return the attestation to Maine HIT Program

C3d2h. Provider Attestation Documentation

From: MaineCare E H R Program Team [<mailto:EhrHelpdesk.DHHS@maine.gov>]

Sent: xx/xx/xx time

To: xxxxxx

Subject: RESPONSE REQUIRED: Last step to receive the Medicaid Meaningful Use payment

Dear xxx,

This email is regarding your application for a Medicaid incentive payment for electronic health records (also called "Meaningful Use").

There is one last step you need to take to complete your attestation (application):

Read the statement below;

1. Hit "reply" (Do NOT hit send yet);
2. Next to "Signature and Date" type in the professional's name and the date;
3. If you are not the professional, but, you are applying on behalf of a professional, also complete the line "Type in YOUR name and date" by typing in your name and the date; and then
4. Hit "send"

The email will automatically come to MaineCare. We will contact CMS to confirm that you did not already receive an incentive payment this payment year from Medicare or another State's Medicaid program.

After we get the confirmation from CMS, we will make the final decision about your incentive payment. (If for any reason there is a question about whether you qualify for a payment, we will contact you before we make a final decision about your application.)

We will then send you an email giving you the payment amount and telling you that it is being deposited in the bank using an Electronic Funds Transfer or a paper check if you do not get your Medicaid payments through an EFT.

Here is the statement:

=====

I certify that the information provided to register and to complete the payment process, is true, accurate, and complete **at the time of this attestation**. I understand that the Medicaid Electronic Health Record (EHR) Incentive Payment request submitted under this professional's number will be

from Federal funds, and that any falsification, or concealment of a material fact may be prosecuted under Federal and State laws.

I certify that I meet the percentage of Medicaid encounters that are required to get an incentive payment and all applicable meaningful use requirements. I agree to keep records required by law to demonstrate that I met all EHR Incentive Program requirements and to furnish those records to the Maine Department of Health and Human Services or the Federal CMS, upon request.

THE SIGNATURE LINE MUST BE COMPLETED.

Signature: Type in the PROFESSIONAL'S name and date: _____
=====

If you are attesting on behalf of a professional, you must type in your name and date below.

I certify that the professional named above has given me authority to act as his/her agent and certifying that the professional agrees with the above statement, including that the professional has met the applicable Medicaid encounter and the meaningful use requirements **at the time of this attestation.**

Type in YOUR name and date: _____

Now you are ready to hit "send." When we receive your reply email, you will have completed the attestation process. MaineCare will then review and process your application as described above.

Thank you,

Jim Leonard
Patti Chubbuck
April Smith
MaineCare E H R Program Team

If you have any questions please feel free to call us at 207-624-4011, or, email us at EHRHelpdesk.DHHS@maine.gov

Figure 78 - Attestation email sent to provider

When the provider has returned the signed attestation the HIT specialist completes the following:

- Attestation email is saved in the provider's record
- SLR is updated
 - Log into the provider's record
 - Select the attestation page
 - Select the Save/Confirm Attestation Eligibility button
 - Select yes to confirm the provider has returned a legally binding document that is

now on file, then click yes

Save / EMAIL ATTESTATION Save / Confirm Attestation Eligibility >>

Home > Provider Details > Attestation > CHKPT - Attestation Eligibility Check

CHKPT - Attestation Eligibility Check

Does the Provider Agree to the Attestation Statement & has returned a legally binding document that is now on file? Pending
(If you are verifying the system or awaiting a response - choose "Pending") Pending
Yes
No

< Back Next >

Figure 79 - Attestation confirmation selection in SLR

The HIT specialist then creates a payment in the SLR and completes the following:

1. Select the Payment button on the provider's record

Provider & Basic Information Eligibility & Encounters EHR SW Attestation

Payments External Elements Subgroups Chk Payee Alternate Email Address

2. Confirm the registration number is for the correct provider then select "Insert New Payment"

Provider Payments

REG ID 1212121212

There are No Payments Scheduled... (Insert New Payment)

< Back INSERT NEW PAYMENT

3. Verify all information on the payment screen
 - a. Current payment year
 - b. State qualification date
 - c. Payee Information
 - d. Medicaid Eligibility calculation method
 - e. The date to pay area will default to the next available payment date. This can be changed to a later date if necessary
 - f. Amount calculated is defaulted to match what program year the provider's registration reflects. This can be changed if necessary.
 - g. Program Year is assigned by the HIT specialist from information supplied on the Medicaid Eligibility worksheet
 - h. Select save and close to create payment

Additional Information
 Current Payment Year 1
 State Qualification Date: 11/05/2015

Payee Information
 Payee Name XYZ Family Practic
 Payee Address 123 Hospital Lane, Augusta, ME 04333
 Payee Phone (207) 111-1111
 Payee NPI 1790789147
 Payee Email xyz@maine.org
 Payee TIN 010211501

Non-Hospital Information
 Fqhc Rhc Based Y
 Is A Pediatrician N
 Needy Encounters 421
 Chip Encounters -
 Medicaid Encounters -
 Total Encounters 697
 Pct Eligible Encounters 60.4

Calculation Method
 For FQHC and RHCs, the percent calculation is based on NEED

Date To Pay 11/11/2015
 Amount Calculated 21250
 Program Year 2015
 << Back Save and Close >>

Figure 80 - Creation of provider payment in the SLR

The summary shows the payment details the HIT specialist has entered

Home > Provider Details > Provider Payments

PAYMENT ID	DATE TO PAY	PAYEE NPI	PAYEE TIN	Type Of Payment	STATUS	Issue Date	Payment Amount	Creation Date	Payment Year	Program Year	Created By
0000006519	11/11/2015	1790789147	010211501	INITIAL	-	-	\$21,250.00	11/06/2015	1	2015	PATTY

Figure 81 - Summary of payment in the SLR

Provider summary page has been updated to show the acceptance of the attestation. The action of creating a payment sends a notice to the audit division that a record is ready for their review. This information is date and time stamped in the SLR

Eligibility Status	Checkpoint Basic Information	Checkpoint Types/Encounters	Checkpoint EHR SW	Checkpoint Attestation	Checkpoint Audit Review	Payment Statuses
Status ELIGIBLE	Passed Y	User PATTY	User PATTY	Passed (S All) Y	Audit Final Ok	D16 Sent
Appl 28-SEP-2015 01:26PM	Date 04-NOV-2015 05:32PM	Passed Y	Passed Y	Attest Sent 05-NOV-2015 05:03PM	Audit Sent 06-NOV-2015 11:56AM	D16 Rcvd
Appl Rcvd 04-NOV-2015 12:00AM	User PATTY	Date 05-NOV-2015 12:24PM	Date 05-NOV-2015 01:25PM	Attest Rcvd 06-NOV-2015 11:39AM	Audit Rcvd	AdvME Sent
Elig Date 04-NOV-2015 05:32PM	PY2+ Appl USER	MU Email -	MU Start -	User PATTY	Audit User -	AdvME Sent
Elig User PATTY	Prensk -	MU Email Sent -	MU End -	Aiu Type A		AdvME Paid
Send Y		MU CS Rcvd 11/02/2015	MU Program -	MU Src -		D18 Sent
B7		MU Approved N/A - PY1	MU Yr -	MU Src Provider -		
			MU Stage -	MU Src Version -		
			Mu Period -			
			Mu Iteration -			

Figure 82 - Summary page updated with listing for audit review

-----Original Message-----
 From: (UAT) EHR_IP_Payment_System [mailto:gregory.tang@maine.gov]
 Sent: Friday, November 06, 2015 11:57 AM
 To: Tang, Gregory
 Subject: (UAT/TEST)Auditor Notification: New EHR Incentive Payment to Review

A Provider has met Eligibility Requirements as determined by a HIT Specialist, and, a Payment has been Submitted that Requires your ****AUDIT REVIEW & APPROVAL****.

Provider : Eggplant, Debbie
 Regid : 1212121212
 NPI : 1212121212
 TIN :
 CCN :

Payment Year : 1
 Program Year : 2015

Scheduled Payment DATE : 11/11/2015
 Scheduled Payment AMOUNT : \$21,250.00

Payment Created by : PATTY
 Payment Entered on : 11-06-2015 @ 11:11:32 AM

Figure 83 - Email notice of record pending audit review

Eligible Providers Pending an AUDITORS Review (Eligible Providers w-Initial Payments that have not passed Final Audit)

row(s) 1 - 1 of 1

Payment ID	Type Of Payment	PPY	REGID	PY	EPEH	Provider	NPI	TIN	CCN	Amount Calculated	Date To Pay	Audit Final Ok
0000006519	INITIAL	2015	1212121212	1		Eggplant, Debbie	1212121212		-	\$21,250.00	11/11/2015	-

Figure 84 - Pending audit list in SLR

The audit division accesses the pending record in the SLR for review. If the audit review raises any questions the HIT specialist is notified. The issue can be addressed by the HIT specialist updating data that may have been entered incorrectly or by contacting the provider for more documentation as needed. The process continues after audit clears the record.

Eligibility Status	Checkpoint Basic Information	Checkpoint Types/Encounters	Checkpoint EHR SW	Checkpoint Attestation	Checkpoint Audit Review	Payment Statuses
Status ELIGIBLE	Passed Y	User PATTY	User PATTY	Passed Y	Audit Y	D16 Sent
Appl Sent 28-SEP-2015 01:26PM	Date 04.NOV.2015 05:32PM	Passed Y	Passed Y	Attest Sent 05-NOV-2015 05:03PM	Audit Sent 06-NOV-2015 11:56AM	D16 Rcvd
Appl Rcvd 04.NOV.2015 12:00AM	User PATTY	Date 05-NOV-2015 12:24PM	Date 05-NOV-2015 01:25PM	Attest Rcvd 06-NOV-2015 11:39AM	Audit Rcvd 06-NOV-2015 12:28PM	AdvME Sent
Elg Date 04.NOV.2015 05:32PM	PY2+ Appl USER -	----	----	User PATTY	Audit User GTANG	AdvME Sent
Elg User PATTY	Preisk -	MU Email -	MU Start 01/01/2014	Attest User PATTY		AdvME Paid
Send B7		MU Email -	MU End 12/31/2014	MU Src Wizard		D18 Sent
		MU Email Sent -	Calc'd Period 365	MU Src EPC5_12121212_7089436c-7198-41ea-be9f-73aa161a4efb.xml		
		MU CS Rcvd 11/02/2015	MU Program -	MU Src Provider Eggplant, Debbie		
		MU Approved N/A - PY1	MU Yr -	MU Src EP Wizard 3.36.5599.26008 MU Year 2014		
			MU Stage -	MU Src Version Stage 2		
			Mu Period -			
			Mu -			
			Iteration -			

Figure 85 - SLR updated post successful audit review

The auditor marks the provider record as accepted. This action automates a D16 file to the NLR for a duplication check to determine the provider has not received a payment for the program year applied for in any other jurisdiction. The SLR shows the payment status for each step once a payment has been created.

Home > Provider Details > Provider Payments > Payment Details

PROVIDER Information	PAYEE Information	PAYMENT Information
Name: Eggplant, Debbie	Payee Name: XYZ Family Practic	Payment Id: 000006519
Address: 489 State Street, Kelley 6, Bangor, ME 04401-4840	Payee Address: 123 Hospital Lane, Augusta, ME 04333	Payment Amount: \$21,250.00
Phone: (207) 945-3800	Payee Phone: (207) 111-1111	Amount Disbursed: -
Email: gregory.tang@maine.gov	Payee NPI: 1790789147	Date To Pay: 11/11/2015
Provider Type: MD	Payee TIN: 010211501	Issued Date: -
REGID: 1212121212	Payee Email: xyz@maine.org	D18 Send Date: -
Provider NPI: 1212121212		Payment Year: 1
Provider TIN: 001221212		Program Year: 2015
Provider CCN: -		State Qualified: 11/05/2015
Program Option: MEDICAID		Created: 11/06/2015
		Type Of Payment: INITIAL
		Last D16: -
		Check Number: -

Admin UAT Features

Payment STATUS: **SEND_D16_DUPECHECK**

AdvME / Payee STATUS: VC2179078914

✓ Payee Vendor - OK

Ⓜ All Vendor - Details

Figure 86 - D16 is auto queued when audit clears record

The D16 is sent to the NLR at 6pm on the day it is set. This is an overnight process with the D16 results received from the NLR the next morning. If no duplication issues are discovered by the NLR the payment status changes to CMS_OK. The details of the D16 check are available by selecting the “View Dupe Payment Details”. The CMS_OK status is noted in the summary screens also.

Home > Provider Details > Provider Payments > Payment Details

PROVIDER Information	PAYEE Information	PAYMENT Information
Name: Eggplant, Debbie	Payee Name: XYZ Family Practic	Payment Id: 000006519
Address: 489 State Street, Kelley 6, Bangor, ME 04401-4840	Payee Address: 123 Hospital Lane, Augusta, ME 04333	Payment Amount: \$21,250.00
Phone: (207) 945-3800	Payee Phone: (207) 111-1111	Amount Disbursed: -
Email: gregory.tang@maine.gov	Payee NPI: 1790789147	Date To Pay: 11/11/2015
Provider Type: MD	Payee TIN: 010211501	Issued Date: -
REGID: 1212121212	Payee Email: xyz@maine.org	D18 Send Date: -
Provider NPI: 1212121212		Payment Year: 1
Provider TIN: 001221212		Program Year: 2015
Provider CCN: -		State Qualified: 11/05/2015
Program Option: MEDICAID		Created: 11/06/2015
		Type Of Payment: INITIAL
		Last D16: -
		Check Number: -

Admin UAT Features

Payment STATUS: **CMS_OK**

AdvME / Payee STATUS: VC2179078914

✓ Payee Vendor - OK

Ⓜ All Vendor - Details

Audit Payment Send Payment to AdvantageME View Dupe Payment Details

Provider Payments

PAYMENT ID	DATE TO PAY	PAYEE NPI	PAYEE TIN	Type Of Payment	STATUS	Issue Date	Payment Amount	Creation Date	Payment Year	Program Year	Created By
000006519	11/11/2015	1790789147	010211501	INITIAL	CMS_OK	-	\$21,250.00	11/06/2015	1	2015	PATTY

Home > Provider Details > Summary

REGID: 1212121212	Provider: Eggplant, Debbie	EHR Cetrum: 1314E01PEGAWEAR	Payment(s) Submitted
NPI: 1212121212	Address: 489 State Street, Kelley 6, Bangor, ME 04401-4840	SLR Cetrum: 1314E01GEXWMEAX	Type of Payment: INITIAL
TIN: 001221212 - SSN	E-mail: gregory.tang@maine.gov	Hospital Based: N	Date To Pay: 11/11/2015
CCN: -	Phone: (207) 945-3800	Is Pediatrician: N	Amount CALC: \$21,250.00
Program: MEDICAID	Payee Provider: XYZ Family Practic	FQHC/RHC Based: Y	Amount PAID: -
Type: MD - Physician	Payee NPI: 1790789147	Total Medicaid Encounters: -	Issued Date: -
Is a Hospital?: N	Payee TIN: 010211501 - EIN	Total Encounters: 697	Status: CMS_OK
MHMS Provider#: 1111111111	Payee Address: 123 Hospital Lane, Augusta, ME 04333	Pct Medicaid Encounters: 60.40	
MHMS Group#: -	Payee Email: xyz@maine.org		
MHMS Location: -	Payment Year: 1		

Transaction Type: ADD

Figure 87 - Return state after D16 has been sent and approved- CMS OK

Once the D16 has been received as CMS_OK the HIT specialist sends the record for payment through AdvantageME – the payment site for disbursement of Medicaid payments.

AdvME Vendorcode: VC2179078914
 ✓ Payee Vendor - OK
 All Vendor - Details

NOTE - Submitting this payment will generate an Automated Payment Notification e-mail to the Provider at >> patricia.chubbuck@maine.gov << indicating a payment has been scheduled for them.

ALERT: An ALTERNATE/SECONDARY Email is being used. The original email is >> gregory.tang@maine.gov <<

Would you like to send this Payment to AdvantageME to have a Provider Payment to be made and monies disbursed?
 Yes
 No

<< Back Next / SUBMIT PAYMENT >>

Figure 88 - HIT specialist sets the payment to be disbursed to provider

The payment status is updated to “Ready to Pay” with the date to pay and payment amount.

Payment(s) Submitted	
Type of Payment	INITIAL
Date To Pay	11/11/2015
Amount CALC	\$21,250.00
Amount PAID	-
Issued Date	-
Status	READY_TO_PAY

Figure 89 - SLR payment status updated to Ready to pay

Payment is disbursed and logged in the SLR with updated status “PAID”

Payment(s) Submitted	
Type of Payment	INITIAL
Date To Pay	11/11/2015
Amount CALC	\$21,250.00
Amount PAID	\$21,250.00
Issued Date	11/11/2015
Status	PAID
AdvME	06-NOV-2015
Send	12:00AM
AdvME	07-NOV-2015
Sent	12:00AM
AdvME	11-NOV-2015
Paid	
D18	
Sent	-

Figure 90 - SLR payment status updated to Paid

The HIT specialist sets the system to send a D18 notice (payment disbursed) to the NLR

Home > Provider Details > Provider Payments > Payment Details

PROVIDER Information
 Name: Egplant, Debbie
 Address: 489 State Street, Kelley 6, Bangor, ME 04401-4840
 Phone: (207) 945-3800
 Email: gregory.tang@maine.gov
 Provider Type: MD
 REGID: 1212121212
 Provider NPI: 1212121212
 Provider TIN: 001221212
 Provider CCN: -
 Program Option: MEDICAID

PAYEE Information
 Payee Name: XYZ Family Practic
 Payee Address: 123 Hospital Lane, Augusta, ME 04333
 Payee Phone: (207) 111-1111
 Payee NPI: 1790789147
 Payee TIN: 010211501
 Payee Email: xyz@maine.org

PAYMENT Information
 Payment Id: 000006519
 Payment Amount: \$21,250.00
 Amount Disbursed: \$21,250.00
 Date To Pay: 11/11/2015
 Issued Date: 11/11/2015
 D18 Send Date: -
 Payment Year: 1
 Program Year: 2015
 State Qualified: 11/05/2015
 Created: 11/06/2015
 Type Of Payment: INITIAL
 Last D16: -
 Check Number: 12345

Payment STATUS
PAID
 AdvME / Payee STATUS: VC2179078914
 ✓ Payee Vendor - OK
 All Vendor - Details

Buttons: Audit Payment, << Back, **Send Payment to NLR - Rpt Disbursement**, View Dupe Payment Details

Figure 91 - Send payment to NLR- Report disbursement

HIT specialist reviews all payment details are accurate then selects yes to send the D18 to the NLR

Home > Provider Details > Provider Payments > Payment Details > Disbursement Details

Review & Approve Final Disbursed Details

ProviderInfo
 NPI: 1212121212
 TIN: 001221212 - SSN
 CCN: -
 Provider: Debbie Egplant
 Legal Name: -

PayeeInfo
 Provider: XYZ Family Practic
 Organization Name: XYZ Family Practic

Status: PAID
 Type Of Payment: INITIAL
 Payment Year: 1
 Expected Date to Pay: 11/11/2015
 Calculated Amount to Pay: \$21,250.00

Actual Amount Disbursed: \$21,250.00
 Issued Date: 11/11/2015
 Check Number: 12345

Would you like to Report the Disbursed Details to the NLR (D18)? [Select- ▼]
 (If you are satisfied with the amount actually paid, choose "YES")

Buttons: < Back, SAVE/Next >>

Would you like to Report the Disbursed Details to the NLR (D18)? Yes ▼
 (If you are satisfied with the amount actually paid, choose "YES")

Buttons: < Back, **SAVE/Next >>**

Figure 92 - Send payment to NLR- Report disbursement

SLR updates payment status to - Send D18 Payment. D18 is sent at 6pm on the day it is set

Home > Provider Details > Provider Payments > Payment Details

PROVIDER Information
 Name: Egplant, Debbie
 Address: 489 State Street, Kelley 6, Bangor, ME 04401-4840
 Phone: (207) 945-3800
 Email: gregory.tang@maine.gov
 Provider Type: MD
 REGID: 1212121212
 Provider NPI: 1212121212
 Provider TIN: 001221212
 Provider CCN: -
 Program Option: MEDICAID

PAYEE Inform
 Payee Name: XYZ Family Practic
 Payee Address: 123 Hospital Lane, Augusta, ME 04333
 Payee Phone: (207) 111-1111
 Payee NPI: 1790789147
 Payee TIN: 010211501
 Payee Email: xyz@maine.org

PAYMENT Information
 Payment Id: 000006519
 Payment Amount: \$21,250.00
 Amount Disbursed: \$21,250.00
 Date To Pay: 11/11/2015
 Issued Date: 11/11/2015
 D18 Send Date: -
 Payment Year: 1
 Program Year: 2015
 State Qualified: 11/05/2015
 Created: 11/06/2015
 Type Of Payment: INITIAL
 Last D16: -
 Check Number: 12345

Payment STATUS
SEND_D18_PAYMENT
 AdvME / Payee STATUS: VC2179078914
 ✓ Payee Vendor - OK
 All Vendor - Details

Buttons: Audit Payment, << Back, View Dupe Payment Details

Return state after D18 accepted by NLR. SLR updated status

Home > Provider Details > Provider Payments > Payment Details

PROVIDER information

Name Eggplant, Debbie
 Address 489 State Street, Kelley 6, Bangor, ME 04401-4840
 Phone (207) 945-3800
 Email gregory.tang@maine.gov
 Provider Type MD
 REGID 1212121212
 Provider NPI 1212121212
 Provider TIN 001221212
 Provider CCN -
 Program Option MEDICAID

PAYEE information

Payee Name XYZ Family Practic
 Payee Address 123 Hospital Lane, Augusta, ME 04333
 Payee Phone (207) 111-1111
 Payee NPI 1790789147
 Payee TIN 010211501
 Payee Email xyz@maine.org

PAYMENT information

Payment Id 000006519
 Payment Amount \$21,250.00
 Amount Disbursed \$21,250.00
 Date To Pay 11/11/2015
 Issued Date 11/11/2015
 D18 Send Date -
 Payment Year 1
 Program Year 2015
 State Qualified 11/05/2015
 Created 11/06/2015
 Type Of Payment INITIAL
 Last D16 -
 Check Number 12345

Payment STATUS
D18_SENT

AdvME / Payee STATUS: VC2179078914
✔ Payee Vendor - OK

[⌵ All Vendor - Details](#)

Admin UAT Features

HOME > PROVIDER DETAILS > PROVIDER PAYMENTS

PAYMENT ID	DATE TO PAY	PAYEE NPI	PAYEE TIN	Type Of Payment	STATUS	Issue Date	Payment Amount	Creation Date	Payment Year	Program Year	Created By
000006519	11/11/2015	1790789147	010211501	INITIAL	D18_SENT	11/11/2015	\$21,250.00	11/06/2015	1	2015	PATTY

row(s) 1 - 1 of 1

Provider record status post payment update in SLR. No changes can be made to the record post D18 to NLR.

Home > Provider Details

Prior Payments

Payment Year 1

****UAT/TEST-Development Version****

SYSTEM_SETUP - ACTIVE_SYSTEM = UAT
HIT15V350U0101

CMS/National Provider Information:

Registration ID : 1212121212
 NPI : 1212121212
 TIN : 001221212 - SSN
 CCN : --
 Provider Name: Debbie Eggplant
 Legal / Business Name : --
 Address : 489 State Street, Kelley 6, Bangor, ME 04401-4840
 Email : gregory.tang@maine.gov
 Program Option : MEDICAID
 Provider Type : MD - Physician

Assigned Payee

Payee NPI 1790789147
 Payee TIN 010211501 - EIN
 Payee Name XYZ Family Practic
 Payee Address 123 Hospital Lane, Augusta, ME 04333

Provider Specialties

No Provider Specialty specified (PECOS-Taxonomy)
ALERT: This Payment Year (#1) has been CLOSED and PAYMENTS have been DISBURSED

Eligibility Information

Is Hospital N
 Entry Date: 09/28/2015
 Application Received: 11/04/2015
 Basic Info Ok: Y - 11/04/2015
 Encounter Ok: Y - 11/05/2015
 Ehr Software Ok: Y - 11/05/2015
 Aiu Attest Ok: Y - 11/06/2015
 Eligibility Status: ELIGIBLE - 11/04/2015

Create a New Payment Year for This Provider

Provider & Basic Information Eligibility & Encounters EHR SW Attestation Manage Tags summary

Payments External Elements Subgroups Chk Payee Alternate Email Address << Back

Home > Provider Details > Summary

REGID 1212121212	Provider Eggplant, Debbie	EHR Certnum 1314E01PE0AWEAR
NPI 1212121212	Address -	SLR Certnum 1314E01QEXWMEAX
TIN -	E-mail -	Hospital Based N
CCN -	Phone -	Is Pediatrician N
Program MEDICAID	Payee Provider XYZ Family Practic	FQHC/RHC Based Y
Type MD - Physician	Payee NPI 1790789147	Total Medicaid Encounters -
Is a Hospital? N	Payee TIN 010211501 - EIN	Total Encounters 697
MIHMS Provider 1111111111	Payee Address 123 Hospital Lane, Augusta, ME 04333	Pct Medicaid Encounters 60.40
MIHMS Group# -	Payee Email xyz@maine.org	
MIHMS Location -	Payment Year 1	
Licensed No Sanctions Y		Transaction Type ADD
Active ✔		Transaction Date 11-SEP-2015 01:01AM
		Transaction Num 9869619-0000003

Payment(s) Submitted

Type of Payment INITIAL
 Date To Pay 11/11/2015
 Amount CALC \$21,250.00
 Amount PAID \$21,250.00
 Issued Date 11/11/2015
 Status D18_SENT

⌵ NLR LOG RPT (All Processes / All PYS)

Payment(s) Submitted

Type of Payment INITIAL
 Date To Pay 11/11/2015
 Amount CALC \$21,250.00
 Amount PAID \$21,250.00
 Issued Date 11/11/2015
 Status D18_SENT

C3d2i. 2015-2017 Stage 2 Modification Rule Changes

CMS recently released a final rule that specifies the meaningful use (MU) objectives that eligible professionals (EPs), eligible hospitals (EHs), and critical access hospitals (CAHs) must meet in order to continue to participate in the Medicare and Medicaid Electronic Health Record (EHR) Incentive programs. The final rule's provisions encompass EHR Incentive Programs in 2015 through 2017 (Modified Stage 2) as well as Stage 3 in 2018 and beyond. MaineCare will be utilizing CMS provided documentation and checklists to ensure that these changes are implemented within the SLR system January 18, 2016, which are effective as of December 14, 2015. The changes for the 2015-2017 Modified State 2 Final Rule will be incorporated into the overall business processes that have been established to run the EHR Incentives Program and can be found in detail listed in Appendix C starting on page 292.⁴⁰ Upon completion of the design and implementation of these changes within the SLR an SMHP addendum will be submitted with these completed screenshots.

The key concepts that MaineCare will follow in 2015 through 2017 (Modified Stage 2) will be aligned with CMS guidance and regulation as follows:

- Restructuring of Stage 1 and Stage 2 objectives and measures to align with Stage 3
 - 10 objectives for EPs, including one consolidated public health reporting objective with measure options
 - 9 objectives for EHs and CAHs, including one consolidated public health reporting objective with measure options
- Starting in 2015, the EHR reporting period will align with the calendar year for all providers
- The EHR reporting period will be changed in 2015 to 90 days to accommodate modifications to meaningful use
- Stage 2 patient engagement objectives will be modified that require “patient action”
- The program will be streamlined by removing redundant, duplicative, and topped out measures
- CQM reporting for both EPs and EH/CAHs will remain as previously finalized

⁴⁰ Hyperlinked Cross-reference

SECTION D – AUDIT STRATEGY

Maine will be submitting its updated 2015 Audit Strategy in a separate document.

SECTION E – MEANINGFUL USE “TO BE,” “GAP ANALYSIS,” AND “ROADMAP”

This section is a compilation of the desired state, the needs to get to the desired state, and the roadmap for getting there. It is divided into eight parts.

Part	Description
1. MITA 3.0 Intent	High-level timeframe and discussion of need for a MITA 3.0 State-Self Assessment to gauge system capabilities against current standards and regulations.
2. Maine Overarching Goals	<ul style="list-style-type: none"> a. Triple Aim b. Value Based Purchasing
3. DHHS Strategic Plan 2013-2015	
4. Office of MaineCare Services Strategic Plan 2015-2018	
5. Maine CDC State Health Improvement Plan 2013-2017	
6. State Innovation Model	<ul style="list-style-type: none"> a. Governance b. Stakeholders and Objectives c. Strengthen Primary Care d. Integrate Physical and Behavioral Health e. Develop New Workforce Models f. Develop New Payment Models g. Centralize Data and Analytics h. Engage People and Communities
7. Integration of Meaningful Use: To-be,” “Gap Analysis,” and “Roadmap”	<ul style="list-style-type: none"> a. Goals (To-Be) b. Objectives (To-Be) c. Status (As-Is/Gap Analysis) d. Needs (Gap Analysis) e. Roadmap
8. Conclusion	

Section E. Part 1. MITA 3.0 Intent

It is the intent of MaineCare to conduct a MITA 3.0 State Self-Assessment (SS-A) within the 2016 calendar year to enhance, further, and align the state's programmatic efforts to aid in the Medicaid systems integration. Since Maine's 2010 MITA 2.01 SS-A there have been several federal updates to the regulations that govern the Medicaid Program. MaineCare would like to align both the current and future systems implementation and development for adherence to the MITA 7 standards and conditions to ensure that development efforts achieve the highest maturity

and capability levels possible. The ultimate product of this SS-A will define Maine's "To-be" state and develop a new roadmap for the 5-10 year plan for input into future versions of the SMHP and IAPD submissions to CMS for enhanced federal funding.

Until this effort is completed MaineCare will focus on accomplishments from the MITA 2.01 SS-A and provide a high-level vision for programmatic alignment and current systems integration efforts through alignment of the DHHS Strategic plan, Office of MaineCare strategic plan, SIM grant, and how the state intends to reach the overarching goals of meeting the Institute for Healthcare Improvement's Triple Aim framework and Value Based Purchasing initiatives.

Section E. Part 2. Maine Overarching Goals

All current activities and systems integrations are aimed at providing the correct quality of care, at the right time, and place to improve care coordination and reduce cost for better patient outcomes. To accomplish this Maine has two overarching goals and principles that all programs and systems across the enterprise are working to achieve.

- 1) Triple Aim**
- 2) Value Based Purchasing**

These initiatives are discussed in greater detail in the sections below but are the major principles that are guiding our systems and programmatic development in addition to the MITA Seven Conditions and Standards. Both initiatives are focused on improving quality of care, health outcomes and reducing program costs

E2a. Triple Aim

The IHI Triple Aim is a framework developed by the Institute for Healthcare Improvement that describes an approach to optimizing health system performance. It is IHI's belief that new designs must be developed to simultaneously pursue three dimensions, which we call the "Triple Aim":

- **Improving the patient experience of care (including quality and satisfaction);**
- **Improving the health of populations; and**
- **Reducing the per capita cost of health care.**

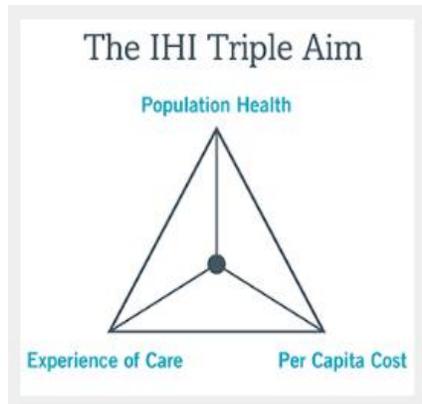


Figure 93 - IHI Triple Aim

There are 5 components aimed to fulfill the IHI Triple Aim in which Maine has incorporated into all of the state Strategic Planning Documents:

- **Focus on individuals and families**
- **Redesign of primary care services and structures**
- **Population health management**
- **Cost control platform**
- **System integration and execution**

E2b. Value Based Purchasing

Value Based Purchasing is the Department’s broad strategy to improve the quality and cost of care for MaineCare members through the Health Homes, Behavioral Health Homes, Accountable Communities, and the State Innovation Model (SIM) Testing grant initiatives. This strategy describes the future of MaineCare service delivery and improved health care and quality. With the advent of HIT, both the historical context of health care delivery and the future can be viewed with an eye towards 21st Century improved health outcomes. The below initiatives have been put into place for the strategic purpose of meeting this goal:

“**Accountable Communities**” means the MaineCare Program of shared savings arrangements with provider organizations that coordinate and/or deliver care to MaineCare populations. (See: <http://www.maine.gov/dhhs/oms/vbp/accountable.html> to view information and documents for the Accountable Care Program.)

“**Health Homes**” means the CMS approved MaineCare Program consisting of primary care practices and community care teams that coordinate and integrate all of a MaineCare Member’s clinical and non-clinical health care-related needs and services. (See: <http://www.maine.gov/dhhs/oms/vbp/health-homes/index.html> to view the MaineCare Benefits Manual, Section 91, Health Home Services.)

“**State Innovation Model (SIM)**” means the CMS approved grant to improve the health of Maine’s population, the experience Maine patients have with their care, and reduce the total costs of care through the development of models that introduce new capabilities to

Maine's healthcare reform efforts. (See: <http://www.maine.gov/dhhs/sim/> to view the CMS approved grant documents.)

E2b1. Value-Based Purchasing (VBP) Strategy

In 2013, the DHHS and OMS began to pursue a Value-Based Purchasing (VBP) strategy in order to improve the quality and cost of care for MaineCare members. The Department stated that they would strengthen the state's collaboration with providers, leverage current programs, and take advantage of emerging federal opportunities. Three major initiatives were later unveiled under this VBP strategy; Health Homes, Behavioral Health Homes, and Accountable Communities. There are over 82,000 MaineCare members currently being served by these programs. DHHS demonstrated a commitment to improving the quality and cost of healthcare for all of Maine by applying for, and being selected to test its plan to achieve the goals of the Triple Aim through an award of a State Innovation Model (SIM) Testing grant from Centers for Medicare and Medicaid Services (CMS). In October of 2013, Maine received grant funds totaling \$33 Million from CMS over the next three years to help Maine achieve the Triple Aim: Improving population health, improving patient experience, and lower the cost of care by 2016. This is an unprecedented partnership among physical and behavioral health providers, public and private insurers, data and system analysts, purchasers, workforce developers, and Maine consumers.

Section E. Part 3. DHHS Strategic Plan 2013-2015

The Department of Health and Human Services (DHHS) is the largest agency in Maine state government. DHHS accounts for thirty-five percent of all state spending and provides social services to hundreds of thousands of needy Maine residents.

Recent economic challenges have brought about intense needs in our state. As our economy recovers, there are still so many who need a helping hand. At the same time, budget constraints at the state and federal levels have made access to resources difficult. In particular, reductions in federal funding have caused a need for more state resources to fill the gap. Since 2008, DHHS has seen staffing reduced by nine percent while programs, caseloads and member needs have grown. The need for efficient and disciplined use of these scarce resources is vital to meeting needs in our communities and securing our safety net for the most vulnerable.

In the face of these challenges, DHHS has made progress and is well-positioned to continue with innovation and reform that improve the delivery of services and make the most efficient use of resources. In the past two years, we have successfully combined several offices within the Department to break down barriers, promote teamwork and provide integrated service to individuals. We recognize that the needs of those we serve span across many programs and that integrated care provides the best option to maximize resources and achieve good outcomes.

We have instituted performance-based contracting, where all agencies that have contracts with the Department now have measures in place that will help DHHS assess their success and will help direct their work. This effort for transparency and accountability includes similar measures for our own goals and initiatives that you see within this plan.

The Department is working with our partners in the community, other state agencies and within our organizational structure to build a Department that coordinates services and provides social and medical assistance with a holistic approach. We are striving to put patients and clients at the center of our work and focus on quality outcomes brought about in the most efficient manner

possible. We are measuring this approach every step of the way to fine tune and improve the process where necessary.

Our leadership is committed to the mission of the Department, our employees and the people we serve. We strive to clearly communicate our direction, support our employees and maximize every resource we have in a shifting economic landscape. This plan will serve as the roadmap to guide our organization forward to best serve Maine's most vulnerable citizens.



Figure 94 - MaineCare DHHS Mission

The Department of Health and Human Services is dedicated to measuring the performance of the Department and holding all areas of our work accountable. Below are several key measures the Department tracks, including the benchmark (most recent data) and the targets DHHS aims to achieve by 2015 (goal 4 target to be achieved by 2016). Additional measures are in development and will be published, along with updates to the data below, in an annual report available to the public.

Goal	Performance Measure	Benchmark	Target
Goal #1 Increase individual and public health	Increase the percentage of Medicaid recipients who are members of a Health Home	16.3%	30%
	Decrease the percentage of Maine adults who are obese	27.8%	25.4%
	Decrease the percentage of Maine adults with diabetes	9.6%	8.5%
Goal #2 Improve self-sufficiency of individuals and families	Increase the percentage of TANF participating adults who are placed in employment over a 12 month period	39.1%	50%
	Increase the percentage of adults with Severe Mental Illness employed in competitive jobs	6.0%	10%
Goal #3 Improve safety of individuals and communities	Increase the percentage of instances where contact is made within 72 hours of intake receiving an allegation of neglect or abuse	83.5%	90%
	Increase the percentage of children in state custody achieving permanency (reunification or adoption) before "aging out" at age 18	85%	99%
Goal #4 Improve school-aged children's ability to succeed	Increase the number of MaineCare children who receive a general developmental screening by age 1, age 2, and age 3	age 1 – 2.1% age 2 – 3.4% age 3 – 0.5%	1 – 11.1% 2 – 12.4% 3 – 9.5%
Goal #5 Ensure efficient use of resources to achieve quality outcomes	Increase the percentage of client service contracts with established performance metrics	67.8%	100%
Goal #6 Increase access and quality for long-term care	Decrease the number of individuals on waitlists for home and community based services	3,100	0
	Increase the percentage of long term care services funding spent on non-institutional home and community based services	49.6%	59.5%

Section E. Part 4. Office of MaineCare Services Strategic Planning Matrix 2015-2018

It is the mission of MaineCare to align programmatic goals and initiatives on both federal and state levels. The Office of MaineCare Services has constructed a plan specific to the Medicaid program in which we propose to help the state of Maine meet the overall goals and objectives of the state’s DHHS Strategic Plan.

MaineCare Vision:
Assure highest quality outcomes for MaineCare members through measurement and an efficient, sustainable, and integrated health delivery system.

Mission Statement:
Our mission is to attain the highest quality health outcomes for MaineCare members through a well-informed workforce and an efficient use of resources.

- **Goal 1: Improve individual and population health**
- **Goal 2: Ensure efficient use of financial resources to achieve measurable health outcomes**
- **Goal 3: Foster a mission oriented, satisfied and effective workforce to achieve organizational excellence**
- **Goal 4: Create a data driven organization**

Goal 1	
Improve individual and population health	
Strategy	Measure/Outcome
Strategy 1.1: Continue to use Value-Based Purchasing to improve quality, cost and access to improve population health	
Strategy 1.1.1: Reduce inappropriate over-utilization of the Emergency Department through care coordination efforts. 1.1.1.1: Identify individuals with two or more inappropriate visits per quarter to the ED through clinical review of claims data.	1. Maintain the existing reduction in non-emergent ED visits and continue reducing by 10% per year for two years (by 2017). 2. Increase utilization in Primary Care Provider (PCP) visits and BH services and specialty care, where appropriate to the member’s care, increase by 10% per year for two years (by 2017).

<p>1.1.1.2: Communicate w/ identified members through outreach letter & phone call.</p> <p>1.1.1.3: Catalog available resources within each community.</p> <p>1.1.1.4: Engage community resources (where available), create and implement care plan (including, but not limited to, Community Care Teams, BH professionals, housing, etc.).</p>	
<p>Strategy 1.1.2: Improve health outcomes for individuals with chronic conditions or diagnosed with Serious and Persistent Mental Illness (SPMI) and Serious Emotional Disturbance (SED).</p> <p>1.1.2.1: Reduce inpatient readmissions.</p> <p>1.1.2.2: Reduce non-emergent use of Emergency Department.</p> <p>1.1.2.3: Improve self-management of chronic conditions.</p> <p>1.1.2.4: Increase access to primary care for individuals with SPMI and SED.</p>	<ol style="list-style-type: none"> 1. Reduce inpatient readmissions by 10% over two years (by 2017). 2. Reduce non-emergent use of the ED by 5% per year for two years (by 2017). 3. Monitor outcomes of individuals with chronic conditions to ensure access to PCP, and work with BHH PCPs to identify resources available to help self-management of these conditions. 4. Ensure all individuals enrolled in HHs with a diagnosis of SPMI or SED have an assigned PCP.
<p>Strategy 1.1.3: Through the use of contracted Accountable Communities, achieve a reduction in avoidable, non-value added costs (e.g., ambulatory sensitive condition, duplication of services, readmits, crisis in ED) while maintaining high quality care.</p> <p>1.1.3.1: Develop attribution methodology and apply against AC participating entities' claims to determine their member panels.</p> <p>1.1.3.2: Collect and analyze the data specific to the lead entities' attributed membership to identify a baseline for savings.</p>	<ol style="list-style-type: none"> 1. Decrease frequency of ambulatory sensitive conditions by 5% per year. 2. Show a decrease in inappropriate ED visits by seeing a 5% increase in the percentage of all ED visits that lead to an inpatient admission. 3. Decrease the number of members receiving crisis services in the ED by 2% in year one and 5% in year two. 4. By end of 2017, have attained double the attributed membership (60,000 members).

<p>1.1.3.3: Generate reports on an agreed upon schedule and supply to AC lead entities for interim performance reporting.</p> <p>1.1.3.4: At the end of the performance period, calculate savings based on claims and reimburse AC lead entities their portion of shared savings based on quality scores.</p> <p>1.1.3.5: Develop and implement a recruitment and retention program to expand attributed members.</p>	
<p>Strategy 1.1.4: Integrate pharmacy management with other VBP initiatives</p> <p>1.1.4.1: Engage with Pharmacy Benefits Manager in a data driven decision making process to expand upon current pharmacy care management initiative to align with other initiatives, such as ACO, ED, HH, etc.</p>	<p>1. By March 31, 2015, develop plan of action (define algorithm to identify members attributed to VBP initiatives and those that will be managed by PBM)</p> <ul style="list-style-type: none"> • For members engaged in VBP initiatives, data will be sent to lead entities regarding drug usage, etc. For those not enrolled, PBM will engage in care coordination strategy. • Establish baseline for medication adherence, drug-to-drug interactions, duplicative meds, gaps in medication therapy (those drugs for those conditions that literature shows to have negative outcomes) to reduce unnecessary complications/costs/hospitalizations.
<p>Strategy 1.1.5: Research best practices and principles applicable to the Medicaid population for Value Based Insurance Design (VBID) based on workgroups established through SIM</p> <ul style="list-style-type: none"> • Incent the use of high value procedures/medications, etc. • Encourage member engagement in care • Accountability 	<p>1. SIM: communication on insurance industry direction, based on workgroup participation. Ongoing monthly meetings through September 30, 2016.</p> <p>2. The workgroup will make recommendations on plan design.</p> <p>3. MaineCare will determine feasibility of VBID and applicability to MaineCare</p>

	populations.
Strategy 1.1.6: Reform Primary Care Provider Incentive Payment (PCPIP) and Primary Care Case Management (PCCM) programs to align with VBP initiatives.	<ol style="list-style-type: none"> 1. Identify quality benchmarks by July 1, 2016. 2. Integrate agreed upon quality benchmarks into policy and payment by July 1, 2017.
Strategy 1.1.7: Collaboration with Office of Aging and Disability Services (OADS) to understand gaps and areas for alignment of the dual-eligible population.	<ol style="list-style-type: none"> 1. By June 2015, engage in discussions with OADS regarding a PACE program for this population. 2. Conduct a review of the impact of the above VBP initiatives on the dual eligible population: <ul style="list-style-type: none"> • HH Stage A by June 30, 2016 • HH Stage B by June 30, 2017 • ACO by December 31, 2017
Strategy 1.2: Align Medicaid quality measures with other payers for better health outcomes	
Strategy 1.2.1: Participate in the quality metrics workgroup for creation of statewide list of quality metrics, across payers.	<ol style="list-style-type: none"> 1. By September 30, 2016, identify a final list of aligned measures.
Strategy 1.2.2: Comprehensive review of all policies and contracts to identify quality metrics currently utilized by VBP and to identify areas that can align with SIM quality metrics.	<ol style="list-style-type: none"> 1. Complete review of current metrics by June 30, 2017. 2. Engage in a continuous improvement of quality measures with all payers, post SIM.
Strategy 1.3: Expand the Partners in Health and Wellness Program (PHW), based on success of the pilot program, to additional families.	
Strategy 1.3.1: Develop a business plan that includes staffing model, data analysis, work benchmarks, and outcome goals.	<ol style="list-style-type: none"> 1. Develop business plan by December 31, 2014.
Strategy 1.3.2: Transition from pilot program to MaineCare	<ol style="list-style-type: none"> 1. Develop DLP and data set for quarterly reports by March 31, 2015.

<p>initiative.</p> <p>Strategy 1.3.2.1: Develop desk level procedure (DLP) that includes interview tool, data collection form, etc.</p> <p>Strategy 1.3.2.2: Identify data set for quarterly reports.</p>	<p>2. Transition to MaineCare initiative by June 30, 2015.</p> <p>3. Submit first quarterly reports by November 15, 2015 and every three (3) months thereafter.</p>
<p>Strategy 1.4: Integrate Improved Health Outcomes of Children (IHOC) into program operations to continue fulfilling the grant's goals and objectives</p>	
<p>Strategy 1.4.1: Create a sustainability plan for operationalizing the initiatives identified in IHOC.</p>	<p>1. Create sustainability plan by December 31, 2014.</p> <p>2. Operationalize plan by March 1, 2015.</p>
<p>Strategy 1.4.2: Identify additional initiatives based on data analysis (e.g., possible addition of adolescent health) that can be operationalized into current IHOC program.</p>	<p>1. Identify new initiatives every 12 months beginning with September 30, 2016.</p> <p>2. Decision to adopt or not and start date identified within three months.</p>

Goal 2	
Ensure efficient use of financial resources to achieve measurable health outcomes	
Strategy	Measure/Outcome
<p>Strategy 2.1: Use Cost Benefit Analysis to create efficiencies in the MaineCare benefit package</p>	
<p>Strategy 2.1.1: Use claims data to identify fragmented care in delivery system by category (e.g., conditions, populations, geography, etc.).</p> <p>Strategy 2.1.1.1: Develop plan to leverage resources, technology, and knowledge to maximize report generation.</p>	<p>1. Episodes of Care analysis to drive care management, initiative use, and policy development.</p> <p>2. Establish a baseline for degree of fragmentation in system and report to Senior Management and Policy Unit.</p> <p>3. Create actionable report from data analysis 18 months after each initiative begins (to allow for 12 months of data to enter the system, after claims lag).</p>
<p>Strategy 2.2: Use data from Program Integrity to inform development of enforceable policies</p>	

<p>Strategy 2.2.1: Collaborate with program integrity on review of audit findings to inform policy decisions.</p>	<ol style="list-style-type: none"> 1. Bi-monthly meetings between policy unit & program integrity. 2. a) Identify the gaps where policies cannot be enforced b) revise policy, based on findings. 3. Program Integrity conducts internal review of policies prior to proposal/adoption.
<p>Strategy 2.3: Compliance with rules, regulations and legal action where federal or state authority is published to avoid financial penalties</p>	
<p>Strategy 2.3.1: Retrospective review of existing policies to identify areas of compliance and non-compliance.</p> <p>2.3.1.1.: Identify the major laws, regulations and legal actions from federal and state perspective.</p>	<ol style="list-style-type: none"> 1. By June 30, 2016, review MaineCare Benefits Manual, policies, State Plan, waivers, and existing audit findings for gaps in compliance with policies and procedures (audits that have occurred since 2010 MIHMS implementation). 2. By December 31, 2016, create document outlining findings and review with Senior Management. 3. By March 31, 2017, produce work plan. 4. Implement work plan.
<p>Strategy 2.3.2: Engage in continuous prospective review of state and federal statutes, policies, and guidance to be adopted in the future.</p>	<ol style="list-style-type: none"> 1. Determine if there is a need for rule change, guidance, etc. 2. Promulgate rule and/or create provider guidance document. 3. Track changes to programs that could impact the MaineCare budget (e.g. drug rebate, recovery of funds, Medicare A/B/D premiums, etc.).
<p>Strategy 2.4: Work with the Commissioner’s Office to promote consistency and alignment among state-funded and MaineCare rates for identical services by the same providers for similar outcomes</p>	

<p>Strategy 2.4.1: Collaborate with other DHHS offices to identify where reimbursement rates are not consistent for identical services by the same provider for Medicaid and non-Medicaid recipients.</p>	<p>1. By December 31, 2014, make recommendations to the Commissioner on establishing a cross-office task force to identify and address discrepancies in reimbursement rates for same services paid from different funding sources.</p>
<p>Strategy 2.5: Assess the efficacy, clinical best practices, and cost for Durable Medical Equipment (DME) and supplies</p>	
<p>Strategy 2.5.1: Explore the feasibility and regulatory authority to test DUR-like approach for DME utilization.</p>	<p>1. By December 31, 2015, report to SMT the feasibility of approach.</p>

<p style="text-align: center;">Goal 3</p>	
<p style="text-align: center;">Foster a mission oriented, satisfied and effective workforce to achieve organizational excellence</p>	
<p>Strategy</p>	<p>Measure/Outcome</p>
<p>Strategy 3.1: Provide access to mission-oriented professional development opportunities to create organizational excellence</p>	
<p>Strategy 3.1.1: Identify core competencies of each unit to achieve the mission (review annually and update as needed).</p>	<p>1. By July 1, 2015, each unit has created a catalog outlining minimum core competencies required to carry out unit's responsibilities.</p> <p>2. By January 1, 2016, all individual evaluations will be updated based upon the minimum core competencies for the unit and communicated with unit members.</p> <p>3. Between July 2015 and January 2016, an OMS overview is compiled and distributed to staff, outlining office-wide competencies.</p>
<p>Strategy 3.1.2: Unit supervisors conduct ongoing (annual) gap analyses of individuals in each unit to identify need and demand for staff training to align with core competencies.</p>	<p>1. Beginning January 1, 2016 through December 31, 2016, all staff will be evaluated against the identified and agreed upon core competencies.</p>

<p>Strategy 3.1.3: Identify available resources to meet need and demand.</p>	<ol style="list-style-type: none"> 1. Between July and October 2015, create inventory of available resources, internally and externally. 2. Between July and October 2015, create inventory of needed, but unavailable, resources. 3. Work with internal training staff, SETU, and others to create availability of needed resources.
<p>Strategy 3.1.4: Communicate the gap(s) and opportunities.</p>	<ol style="list-style-type: none"> 1. Between July and October 2015, implement unit-based communication about gap(s) and opportunities. 2. Between July and October 2015, conduct staff-specific communication about individual gap(s) and opportunities.
<p>Strategy 3.1.5: Identify organization-wide core competencies for directors, managers, and supervisors.</p>	<ol style="list-style-type: none"> 1. By July 1, 2015, each unit has engaged DHHS Director of Workforce Development to create a catalog outlining minimum core competencies required of directors, managers, and supervisors.
<p>Strategy 3.2: Support opportunities for individual professional growth</p>	
<p>Strategy 3.2.1: Catalog and communicate the known resources that are available for staff professional growth opportunities.</p>	<ol style="list-style-type: none"> 1. By July 1, 2015, engage DHHS Director of Workforce Development to create and distribute catalog of available resources for professional growth opportunities, including self-directed professional growth.
<p>Strategy 3.2.2: Solicit management input throughout MaineCare to develop an organization-wide strategy that supports individual professional growth interests among staff.</p>	<ol style="list-style-type: none"> 1. By September 1, 2015, create communication plan for strategy roll out to staff.
<p>Strategy 3.3: Through project planning, create operational efficiency and alignment in the organization</p>	

<p>Strategy 3.3.1: Create and monitor operational planning tool.</p>	<ol style="list-style-type: none"> 1. By July 30, 2015, an operational planning template has been created and provided to each unit, along with necessary training on how to use work plan. 2. All units have a master work plan to track progress of initiatives and workflow (to include work to be completed, timeline, needed resources/reports, etc.). 3. On a quarterly basis, at the managers and supervisors meetings, each unit provides updates and an overview of their work plans with time allocated for highlighting accomplishments and appreciative inquiry. 4. Enhance, through training and the use of complementary case study approach, a continued movement toward the use of cross-functional teams within OMS to accomplish operational efficiency.
<p>Strategy 3.3.2: Receive monthly admin and staffing budget updates from PFC to help achieve organizational alignment.</p>	<ol style="list-style-type: none"> 1. Beginning July 1, 2015, OMS will receive reports from PFC that will allow for fiscal accountability and resource management.

Goal 4	
Create a data driven organization	
Strategy	Measure/Outcome
Strategy 4.1: Implement a data analysis structure to create consistent reporting	
<p>Strategy 4.1.1: Engage in a consistent reporting structure to increase credibility, efficiency and quality of reports.</p>	<ol style="list-style-type: none"> 1. By March 1, 2015, a data definition team will create standard definitions and use of MaineCare claims data that can be utilized across DHHS. This team will review these definitions on a regular basis. 2. By July 1, 2015, MaineCare claims glossary with standard definitions for: Services, populations, demographics, diagnosis, procedure codes, outcomes, etc. 3 By January 1, 2016, build data query

	<p>repository to provide access to MaineCare claims data that is standardized for end users.</p> <p>4. By March 31, 2016 develop a training program so that staff can interpret and utilize reports (refer to strategy 3.1, re: core competencies).</p>
<p>Strategy 4.2: Scorecard for MaineCare that define how resources are being expended and utilization trends</p>	
<p>Strategy 4.2.1: Communicate financial and utilization information via scorecard.</p>	<p>1. By April 30, 2016, produce quarterly report established that consists of top 10 object codes forecasted expenditures and actual expenditures.</p> <p>2. Engage other DHHS offices to get feedback on quarterly reports.</p>
<p>Strategy 4.3: Conduct situation assessment of current data structure and gaps against the needs to support changing healthcare delivery</p>	
<p>Strategy 4.3.1: Conduct situation assessment of current data structure and gaps against the needs to support changing healthcare delivery.</p>	<p>1 By December 31, 2015, define current data infrastructure and sources.</p> <p>2. March 31, 2016, conduct gap analysis.</p> <p>3. By June 30, 2016, report findings of gap analysis and identify strategies to fill gap.</p>

Section E. Part 5 Maine CDC State Health Improvement Plan 2013-2017

The Maine Center for Disease Control and Prevention (Maine CDC), an office of the Maine Department of Health and Human Services (DHHS), is responsible for providing essential public health services that preserve, promote, and protect health. Many organizations, both public and private, share this goal. This Plan reflects the public health priorities of the Maine CDC and Maine DHHS, with significant input from our public health partners. The State Health Improvement Plan (SHIP) is designed to improve the health of all Maine people.

In 2011 the Maine Department of Health and Human Services (DHHS) began a process to engage public health partners in the creation of a statewide plan to improve the health of Maine people. As the State’s public health agency, the Maine Center for Disease Control and Prevention (Maine CDC) has the responsibility to provide essential public health services to preserve, promote, and protect health.

The overarching vision of Maine CDC is: “Maine people living safe, healthy and productive lives.” This vision is accomplished through its mission to: “Provide integrated health and human

services to the people of Maine to assist individuals in meeting their needs, while respecting the rights and preferences of the individual and family, within available resources.”

Maine DHHS programs and services are planned and delivered by the Maine CDC as well as by MaineCare Services (State Medicaid Program); Substance Abuse and Mental Health Services; Aging and Disability Services; Family Independence; and Child and Family Services. This plan focuses on six health priorities, with goals, objective, and strategies for achieving measurable success over the next three years.

Priorities	Goals	Objectives	Strategies
Immunizations	Increase immunization rates in Maine by an average of 10% by June 2017.	Objective 1 Childhood Routine Immunization Schedule	1.1. Educate health care providers on use of reminder/recall system. 1.2. Encourage provider enrollment and use of state registry. 1.3. Educate health care providers who are fully integrated in the state registry on the importance of keeping their client immunization history information up to date and identifying and disassociating former clients who have moved or gone elsewhere. 1.4. Provide quarterly assessment reports to health care providers that are fully integrated into the ImmPact system (Maine immunization information system). 1.5. Conduct Assessment, Feedback, Incentives, eXchange of Information (AFIX) site visits to a minimum of 25% of Maine health care providers enrolled in the Vaccines for Children (VFC) program.
		Objective 2 Adolescent Routine Immunization Schedule	2.1. Educate health care providers on use of reminder/recall system. 2.2. Encourage provider enrollment and use of state registry. 2.3. Educate health care providers who are fully integrated in the state registry on the importance of keeping their client immunization history information up to date and identifying and disassociating former clients who have moved or gone elsewhere. 2.4. Provide quarterly assessment reports to health care providers that are fully integrated into the

			<p>ImmPact system.</p> <p>2.5. Conduct AFIX site visits to a minimum of 25% of Maine health care providers enrolled in the VFC program.</p>
		<p>Objective 3 Adolescent Human Papillomavirus (HPV)</p>	<p>3.1. Provide assessment and feedback information to health care providers on current HPV vaccination rates and suggestions for methods to improve clinical rates.</p> <p>3.2. Educate health care providers who are fully integrated in the state registry on the importance of keeping their client immunization history information up to date and identifying and disassociating former clients who have moved or gone elsewhere.</p> <p>3.3. Provide quarterly assessment reports to health care providers that are fully integrated into the ImmPact system.</p> <p>3.4. The Maine Immunization Coalition will disseminate best practice information to health care providers and school based health centers on HPV vaccinations.</p>
		<p>Objective 4 Seasonal Flu</p>	<p>4.1. Identify underserved areas of need and work with School Administrative Units (SAUs) to increase the number of SAUs offering seasonal influenza vaccine.</p> <p>4.2. Identify and recruit community partners to support and assist with school located vaccine clinics (SLVC).</p> <p>4.3. Build a sustainable billing structure to cover vaccine administration costs associated with conducting SLVCs in Maine schools to include private health insurance reimbursement.</p>
		<p>Objective 5 Adult Pertussis</p>	<p>5.1. Develop a packet of information for obstetric providers to include: the need and rationale for pertussis vaccine in pregnancy, recommended guidelines for administering pertussis</p>

			<p>vaccine, and reminder/recall systems.</p> <p>5.2. MIP will send information packet to all enrolled providers.</p> <p>5.3. Work with provider organizations to establish a baseline of providers who have new Tdap guidelines.</p>
		<p>Objective 6 Pneumococcal Vaccination Among Seniors</p>	<p>6.1. Explore possibilities for accessing, aggregating, and analyzing relevant population-level data for pneumococcal vaccinations in order to identify areas of need and facilitate strategic targeting of vaccinations and tracking of progress toward this objective.</p> <p>6.2. Increase public and provider awareness of the recommendations for pneumococcal vaccination and execute proven communication strategies to engage both primary care providers and community partners/organizations who serve seniors in promoting pneumococcal vaccination.</p>
<p>Obesity</p>	<p>Reduce adult obesity in Maine by 5% and youth obesity by 10% by June 30, 2017</p>	<p>Objective 1 Decrease Sugar-Sweetened Beverage Consumption</p>	<p>1.1. Increase outreach and education to the public and to partners, using currently available resources to decrease consumption of sugar sweetened beverages.</p> <p>1.2. Implement a media campaign to raise public awareness of the relationship between sugar sweetened beverages and obesity.</p> <p>1.3. Encourage school departments to limit access to sugar-sweetened beverages in schools.</p> <p>1.4. Encourage providers to include screening and counseling on sugar-sweetened beverage consumption as part of routine medical care.</p> <p>1.5. Discourage the consumption of sugar sweetened beverages by seeking a waiver from the federal government to disallow the use of Supplemental Nutrition Assistance Program (SNAP) benefits for purchase of sugar</p>

			sweetened beverages.
		Objective 2 Increase Fruit and Vegetable Consumption	<p>2.1. Increase outreach and education to the public and to partners, using currently available resources, to guide increased consumption of fruits and vegetables.</p> <p>2.2. Promote Food Policy Councils as a way to increase access to affordable healthy foods for all Maine people.</p> <p>2.3. Increase or expand fruit and vegetable market outlets such as farm to institution, farm to school, farmers' markets.</p> <p>2.4. Increase participation in Fresh Fruit and Vegetable Program (FFVP) by maximizing the use of federal funds so that more schools can join.</p>
		Objective 3 Increase Physical Activity	<p>3a.1. Work with municipalities to increase opportunities for active transportation and access to indoor and outdoor recreational facilities. This includes, for example, increased sidewalks, bike path trails for public use, and 'complete street' components, and would be done in compliance with Americans with Disabilities Act Accessibility Guidelines (ADAAG).</p> <p>3b.1. Work with school departments to increase the number of schools that provide public access to indoor and outdoor school facilities for out-of-school physical activity.</p> <p>3b.2. Work with childcare centers to increase the number of centers using evidence based approaches (e.g. Nutrition And Physical Activity Self-Assessment for Child Care (NAP SACC), Let's Move!) to implement policies and create environments that support physical activity and meet safety guidelines.</p> <p>3b.3. Work with schools to increase the proportion of middle and high school students who attend daily</p>

			physical education classes, including increasing school offerings of daily physical education classes and student participation in them.
		Objective 4 Breastfeeding	<p>4.1. Educate employers on how to comply with Maine Workplaces Support Nursing Moms law in order to support employees who are breastfeeding (including a private location to pump, flextime, and breast milk storage space).</p> <p>4.2. Educate mothers about Maine Workplaces Support Nursing Moms law along with other applicable laws and resources for lactation support.</p> <p>4.3. Educate child care centers on how to create and implement policies and environments that support breastfeeding.</p> <p>4.4. Educate birthing facilities in Maine on the Baby-Friendly Hospital Initiatives 10 Steps to Successful Breastfeeding in order to increase the percentage of infants ever breastfed (including infants in a Maine neonatal intensive care unit (NICU) setting).</p>
Substance Abuse and Mental Health	Reduce substance abuse and improve mental health in Maine by 5% by June 2017. <i>(This goal encompasses a number of specific Healthy Maine 2020 objectives and approximately 50% toward the Healthy Maine</i>	Objective 1 Early Intervention	1.1.Continue education of MaineCare health home practices in the use of developmental screening tools and in the submission of claims for the screenings through Improving Health Outcomes for Children (IHOC), the Patient Centered Medical Home (PCMH) Learning Collaborative administered by Maine Quality Counts, and the training being developed and implemented under the State Innovation Model (SIM) grant for primary care practices serving children with developmental disabilities.

	2020 goals.)		
		Objective 2 Physician Drug Protocols	<p>2.1. Develop and distribute a fact sheet with key elements for drug-prescribing protocols and resources.</p> <p>2.2. Identify Continuing Medical Education (CME) opportunities that are quality and user-friendly; obtain approval and buy-in from Maine Medical Association (MMA), Maine Osteopathic Association (MOA), Nurse Practitioner and Physician Assistant associations, and Maine Primary Care Association (MPCA).</p> <p>2.3. Identify a method to assess the status of drug prescribing protocols within a system of care.</p> <p>2.4. Investigate how to integrate drug-prescribing protocols into electronic medical records (EMR).</p>
		Objective 3 Coordination of Care	<p>3a.1. Educate physician practices in the use of SBIRT tools and billing codes.</p> <p>3a.2. Explore and learn more about the use of SBIRT in electronic medical records developed by Eastern Maine Healthcare Systems.</p> <p>3b.1. Educate MaineCare health home practices in the use of depression and substance abuse screening tools through the Patient Centered Medical Home Learning Collaborative.</p> <p>3c.1. Provide education and training to primary care providers, including staff of school based health centers, on the integration and use of nationally recognized evidence-based suicide prevention screening and assessment tools.</p> <p>3c.2. Provide Maine's Gatekeeper training to all public school staff: a one day program that includes skills practice and has been shown to significantly increase a respondent's</p>

			knowledge of warning signs and risk factors for suicide as well as enhanced confidence in the ability to intervene.
		Objective 4 Access to Care	<p>4.1. Develop a train-the-trainer program based on Substance Abuse and Mental Health Services Administration’s Mental Health First Aid program.</p> <p>4.2. Promote public service announcements using messages already developed (bringchangetomind.org).</p> <p>4.3. Engage physician practices in a learning collaborative to adopt NIATx (Network for Improvement of Addiction Treatment Services) principles that have been shown to consistently influence efforts to overcome barriers to process improvement (http://www.niatx.net/Content/ContentPage.aspx?NID=131).</p> <p>4.4. Explore resources to expand telehealth to areas in Maine with few mental health resources.</p> <p>4.5. Explore resources for education for primary care providers to reduce stigma-related barriers to care via the SIM grant and behavioral health home training initiative.</p>
Tobacco Use	Reduce adult and adolescent tobacco use in Maine by 5% by June 2017. (This is approximately 50% toward the Healthy Maine 2020 goals.)	Objective 1 Treatment	<p>1.1. Promote Partnership for a Tobacco-Free Maine (PTM) clinical outreach sessions to increase brief tobacco interventions in clinical settings.</p> <p>1.2. Promote PTM basic skills training to increase brief tobacco interventions in clinical settings.</p> <p>1.3. Promote Intensive Tobacco Cessation training.</p>
		Objective 2 Policy and Environmental Change	2.1. Increase the number of organizations and local communities that have voluntarily adopted smoke-free or tobacco-free policies and maintain current strong protections from secondhand smoke

			under Maine law.
		Objective 3 Second Hand Smoke	<p>3.1. Implement a statewide public awareness campaign about environmental tobacco smoke exposure and the effects on children in the home.</p> <p>3.2. Work with partners to increase the number of families who have rules against smoking in their home by adopting the smoke-free homes pledge.</p> <p>3.3. Work with partners to increase the number of landlords and property managers of subsidized housing, such as those accepting Section 8 vouchers, who have adopted smoke-free policies.</p> <p>3.4. Train childcare and head start staff on messaging about the dangers of environmental tobacco smoke exposure and tobacco treatment resources available through the Maine Helpers' Training Program.</p>
		Objective 4 Disparities	<p>4.1. Promote clinical outreach and attendance at PTM basic skills training among providers that currently serve populations with health disparities. These partner organizations include Federally Qualified Health Centers, Indian Health Centers, behavioral health agencies, OB-GYN providers, and providers to Lesbian, Gay, Bi-sexual, Transgender (LGBT) individuals that currently serve populations with health disparities. These populations include: individuals with a behavioral health diagnosis, LGBT individuals, refugees and immigrants, pregnant women insured through MaineCare, Native Americans, and low socioeconomic populations.</p> <p>4.2. Promote the development of comprehensive tobacco-free policies for all provider sites; refer to Breathe Easy Coalition standards.</p>

			<p>4.3. Promote electronic communication such as websites, listserves, Twitter, Facebook and newsletters that are specific to the population such as Project Integrate for Behavioral Health populations.</p> <p>4.4. Promote the Maine Helpers' Program to organizations that currently serve populations with health disparities.</p>
		Objective 5 Youth	<p>5.1. Support organizations that provide leadership training to youth around tobacco cessation.</p> <p>5.2. Implement evidence-based tobacco prevention curricula in schools.</p> <p>5.3. Engage youth in supporting the development and implementation of evidence-based tobacco prevention policy changes.</p>
Inform, Educate and Empower the Public	Increase Maine's capacity to inform, educate and empower Maine people about health issues by June 2017.	Objective 1 Message Delivery System	<p>1.1. Map the public health information, health education, and health promotion delivery system to identify and address gaps, including message accessibility.</p> <p>1.2. Develop a customer usage survey to understand and improve the reach of the current messaging delivery systems to identify accessibility, understanding, and applicability. The survey is intended to be used by Maine CDC, HMPs, hospital systems, Federally Qualified Health Centers, Tribal Health Departments, and others.</p> <p>1.3. Convene quarterly Maine CDC meetings for health educators and other health education staff for knowledge sharing and skill building on public health communications</p> <p>1.4. Develop a Memorandum of Understanding between DCCs and partner organizations for dissemination of Maine CDC health messages.</p>
		Objective 2 Cross-	2.1. Identify and convene stakeholders

		Cultural, Plain Language Communication	<p>from different public and private sectors who are willing to collaborate on developing and sharing plain language resources that are appropriate across different cultures within Maine.</p> <p>2.2. The Maine CDC will develop procedures for development and review of plain-language and culturally and linguistically appropriate communications.</p> <p>2.3. Identify and/or create measures to determine who is accessing cross-cultural, plain language materials and how.</p> <p>2.4. Develop a statewide process for dissemination of cross-cultural plain language resources.</p>
Mobilize Community Partnerships	Increase Maine’s capacity to mobilize community partnerships and action to identify and solve health problems by June 2017.	Objective 1 Increase Community Partnerships	<p>1.1. Local coalitions and health departments will identify gaps in representation and recruit to ensure all target populations are being adequately represented in our efforts.</p> <p>1.2. Each DCC will review representation annually, identify gaps in representation, and seek to fill those gaps.</p> <p>1.3. The SCC will annually review representation, identify gaps, and seek to fill those gaps.</p>
		Objective 2 Increase Awareness of Public Health to Increase Visibility and Encourage Engagement	<p>2.1. Identify resources such as This is Public Health stickers, use of national public health logo, posters, etc.</p> <p>2.2. Distribute resources to community public health partners.</p> <p>2.3. Initiate discussions with Maine CDC administration about strategies to raise awareness of what public health is and its value.</p>

Section E. Part 6. Maine State Innovation Model

Maine believes that its healthcare system can improve the health of Maine people, advance the quality and experiences of healthcare, and reduce healthcare costs by 2016. The State has embarked on a three year unprecedented partnership among physical and behavioral health providers, public and private insurers, data and system analysts, purchasers, workforce developers, and Maine consumers to put this belief to the test through the Maine State Innovation Model (SIM). Federal partners are confident in its potential and have funded Maine and five other states to each implement their state level healthcare innovation reform plan.

The Maine SIM intends to achieve the Triple Aim goals of improving the health of Maine's population, improving the experience Maine patients have with their care, and reducing the total costs of care. The model has a foundation in emerging healthcare initiatives, promising community-based demonstration projects, and evidence-based strategies that empower consumers with long-term health conditions. The power of the innovation, however, comes from the concurrent application of existing efforts with enhanced investments, all within a shared commitment to accountability, transparency, and quality.

The Maine State Innovation Model award has four primary objectives aimed at achieving the Triple Aim:

- 1. Reduce the total cost of care per member per year in Maine to the national average;**
- 2. Improve the health of Maine's population in at least four categories of disease prevalence (including diabetes, mental health, obesity, and tobacco use);**
- 3. Improve patient experience scores for targeted practices by 2% from the baseline 2012 survey;**
- 4. Increase the number of practices reporting patient experience information from 50% to 66%.**

To accomplish these goals the State of Maine has contracted with organizations throughout the state that have a proven track record for successfully engaging in payment reform, delivery system reform, data analytics and reporting, health information technology (HIT), and consumer engagement.

The SIM grant in some cases accelerates and broadens the current innovations occurring throughout Maine, and in other cases introduces new capabilities to Maine's healthcare reform efforts. SIM enables these innovative tests to more effectively determine what reform efforts are working, and, just as importantly, to determine what is not working as effectively.

There are six strategic pillars of the State Innovation Model (*below*) are each comprised of individual objectives that are aligned to effect meaningful change in our healthcare system. The following sections provide an overview of the work being undertaken in each pillar, and how it is progressing to date. For a detailed description of SIM objectives visit www.maine.gov/dhhs/sim.

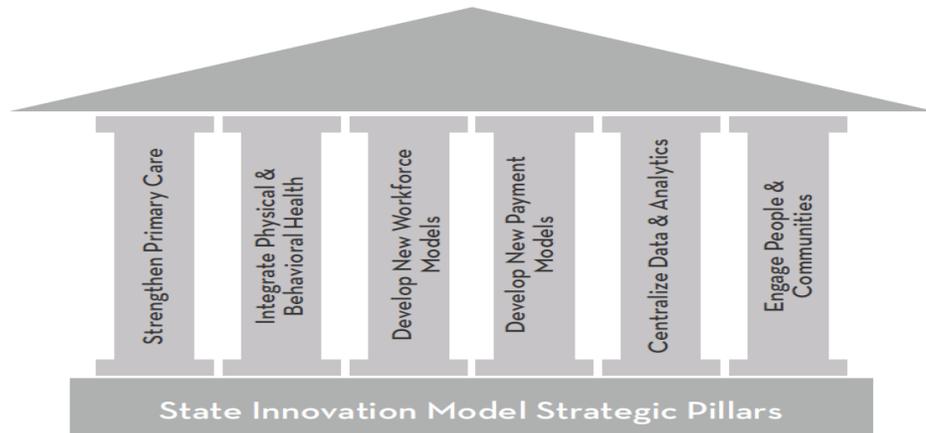


Figure 95 - SIM Strategic Pillars

E6a. SIM Governance

The State of Maine believes that lasting, transformative change most effectively occurs through the development of a broad, highly credible, collaborative network that is passionate, engaged and empowered to influence reform action. The SIM Governance process matured significantly during Test Year One, as all the SIM governance committees and subcommittees transitioned from a learning mode to a decision making mode. The State of Maine serves as the lead convener of the SIM governance process, which includes the Maine Leadership Team, the SIM Steering Committee, and three subcommittees: Payment Reform, Delivery System Reform, and Data Infrastructure subcommittees, which are facilitated by the Maine Health Management Coalition, Quality Counts, and HealthInfoNet respectively. The Evaluation subcommittee, with the DHHS office of Continuous Quality Improvement in the lead, will begin work in the first quarter of year two. In addition, multiple workgroups were formed or enhanced as a result of SIM, including but not limited to, the Accountable Care Implementation subcommittee, the Measure Alignment workgroup, HealthCare Cost workgroup, and the Value Based Insurance Design workgroup, among others. Some highlights to date of the governance decisions made during SIM’s first year include the collaboration toward a care coordination strategy, the focus on alignment of a core measure set, the initial review of methods to accelerate primary care payment reform, and the finalization of a healthcare transformation leadership development program. Engagement of the stakeholders on SIM governance structure continues to remain robust throughout year two of the program. ([Download SIM Governance Overview](#))

Maine SIM Leadership Team⁴¹ has responsibility for policies, changes to the work plan, major shifts in resource allocation, and decisions requiring senior authority to make project changes and decisions.

SIM Steering Committee⁴² includes representation from a broad range of stakeholders, ranging from the state’s Bureau of Insurance to a Medicaid member. The projects Steering Committee Chair will report on a bi-annual basis.

⁴¹ Item is Hyperlinked to Maine SIM Leadership Team Roster

⁴² Item is Hyperlinked to Maine SIM Steering Committee Team Roster

E6a1. SIM Program Administration

The SIM Program operationalization matured and solidified over the course of the project, as the SIM Program Plan was enhanced to include processes that tied together project goals and reporting, invoicing, contracting, and overall integration. The SIM Program Plan, and the associated process, has become known as the ‘Single Source of Truth’, due to the degree to which it serves as SIM Command Central, integrating and relating all of the dozens of SIM activities that occur simultaneously and need to remain integrated and coordinated. The process developed to manage Maine’s SIM grant has served as a best practice and has been emulated and adapted for use throughout the State of Maine’s Department of Health and Human Services which is crucial for business process development as we work to adapt to the MITA Seven Conditions and Standards.

E6b. SIM Stakeholders and Objectives

E6b1. The Office of MaineCare Services

OMS oversees the MaineCare program (also known as Medicaid), Maine Rx Plus, and drugs for the Elderly and Disabled. MaineCare Services coordinates the programs and benefits, assures that they operate under consistent policy in keeping with the Department’s goals and Federal mandates, and ensures that they are administered effectively and efficiently.

OMS SIM Objectives:

- **MaineCare Objective 1 - Implement MaineCare Accountable Communities Shared Savings ACO Initiative**
- **MaineCare Objective 2- Implementation and ongoing support of MaineCare Behavioral Health Homes Initiative**
- **MaineCare Objective 3- Develop and implement physical health integration workforce development component to Mental Health Rehabilitation Technician/Community (MHRT/C) Certification curriculum**
- **MaineCare Objective 4- Provide training to primary care practices on serving youth and adults with Autism Spectrum Disorder and intellectual disabilities**

Strengthen Primary Care	Integrate Physical & Behavioral Health	Develop New Workforce Models	Develop New Payment Models	Centralize Data and Analysis	Engage People and Communities
MaineCare Objective 1	MaineCare Objective 2	MaineCare Objective 3	MaineCare Objective 1		
Implement MaineCare Accountable Communities Shared Savings ACO Initiative	Implementation and ongoing support of MaineCare Behavioral Health Homes	Develop and implement physical health integration workforce development	Implement MaineCare Accountable Communities Shared Savings		

	Initiative	component to Mental Health Rehabilitation Technician/Community (MHRT/C) Certification curriculum	ACO Initiative		
MaineCare Objective 4					
Provide training to primary care practices on serving youth and adults with Autism Spectrum Disorder and intellectual disabilities					

E6b2. Maine Health Management Coalition

The Maine Health Management Coalition (MHMC) is a non-profit organization whose over 60 members include public and private employers, hospitals, health plans, and doctors working together to measure and report health care value. The MHMC helps employers and their employees use this information to make informed decisions.

Since 1993, the MHMC has played a leading role in health care quality measurement and public reporting, both in Maine and nationally, and has acted as a catalyst for quality improvement. Quality rankings for Maine hospitals and primary care physicians are available at www.getbettermaine.org.

The MHMC was selected by the State of Maine as the lead implementation partner for the State Innovation Model (SIM) award, and will be contributing to a number of payment reform, delivery system reform, data analytic, and consumer engagement aspects of the work. For more information visit www.mehmc.org.

MHMC SIM Objectives:

- **MHMC Objective 1- Track healthcare costs to influence market forces and inform policy.**
- **MHMC Objective 2- Stimulate Value Based Insurance Design.**
- **MHMC Objective 3- Public reporting for quality improvement and payment reform.**
- **MHMC Objective 4- Provide primary care providers access to claims data for their patient panels (portals).**

- **MHMC Objective 5- Provide practice reports reflecting practice performance on outcome measures**
- **MHMC Objective 6- Consumer engagement and education regarding payment and system delivery reform.**

Strengthen Primary Care	Integrate Physical & Behavioral Health	Develop New Workforce Models	Develop New Payment Models	Centralize Data and Analysis	Engage People and Communities
MHMC Objective 4		MHMC Objective 3	MHMC Objective 3	MHMC Objective 1	MHMC Objective 6
Provide primary care providers access to claims data for their patient panels(portals)		Public reporting for quality improvement and payment reform	Public reporting for quality improvement and payment reform	Track healthcare costs to influence market forces and inform policy	Consumer engagement and education regarding payment and system delivery reform
MHMC Objective 5			MHMC Objective 2	MHMC Objective 3	
Provide practice reports reflecting practice performance on outcome measures			Stimulate Value Based Insurance Design	Public reporting for quality improvement and payment reform	
			MHMC Objective 5		
			Provide practice reports reflecting practice performance on outcome measures		

E6b3. Maine Quality Counts

Maine Quality Counts (QC) is an independent, nonprofit regional health improvement collaborative committed to improving health and health care for the people of Maine by leading, coordinating, and aligning improvement efforts. QCs vision is: Through the active engagement and alignment of people, communities and healthcare partners, every person in Maine will enjoy

the best of health and have access to patient centered care that is uniformly high quality, equitable and efficient.

Under Maine’s SIM award, Maine Quality Counts (QC) will serve as a contractor to the state to provide quality improvement services to help strengthen primary care practices, and to support expansion of quality improvement support to the Patient Centered Medical Home (PCMH) and Health Homes efforts in Maine.

The state will specifically look to QC to support an expanded learning collaborative to provide quality improvement assistance to up to 70 additional primary care practices that have stepped forward to participate in the MaineCare Health Homes initiative. For more information visit www.mainequalitycounts.org

QC SIM Objectives:

QC Objective 1- Provide learning collaborative for MaineCare Health Homes.

QC Objective 3- Provide QI support for Behavioral Health.

QC Objective 4- Provide QI support for Patient-Provider Partnership Pilots (P3)

Strengthen Primary Care	Integrate Physical & Behavioral Health	Develop New Workforce Models	Develop New Payment Models	Centralize Data and Analysis	Engage People and Communities
QC Objective 1	QC Objective 1	QC Objective 1	QC Objective 1		QC Objective 4
Provide learning collaborative for MaineCare Health Homes	Provide learning collaborative for MaineCare Health Homes	Provide learning collaborative for MaineCare Health Homes	Provide learning collaborative for MaineCare Health Homes		Provide QI support for Patient-Provider Partnership Pilots (P3 Pilots)
QC Objective 4	QC Objective 3	QC Objective 3			
Provide QI support for Patient-Provider Partnership Pilots (P3)	Provide QI support for Behavioral Health Homes Learning Collaborative	Provide QI support for Behavioral Health Homes Learning Collaborative			

E6b4. HealthInfoNet

HealthInfoNet is an independent, nonprofit organization using information technology to improve patient care quality and safety. HealthInfoNet built and operates Maine’s statewide

health information exchange (HIE), a secure electronic system where health care providers share important patient health information including allergies, prescriptions, medical conditions, and lab and test results. HealthInfoNet is also the Regional Extension Centers (REC) for the State of Maine, providing education and technical assistance to help health care providers select, implement, and achieve meaningful use of certified EHR technology. HealthInfoNet incorporated in 2006 and is governed by a board of directors and several committees run by Maine people serving on behalf of doctors, hospitals, public health, patients, and groups representing various consumer interests. The organization provides services across the State of Maine, and maintains administrative offices in Portland. For more information visit www.hinfonet.org.

HIN SIM Objectives:

HIN Objective 1- HIN’s Health Information Exchange (HIE) data will support both MaineCare and provider care management of ED and inpatient utilization by sending automated emails to care managers to notify them of a patient’s visit along with associated medical record documents.

HIN Objective 2- HIN will select 20 qualified Behavioral Health Organizations to provide \$70,000 each towards their EHR investments including their ability to measure quality.

HIN Objective 3- Connect 20 behavioral health providers to HIN’s Health Information Exchange.

HIN Objective 4- HIN will provide MaineCare with a web-based analytics tool referred to as a “dashboard.” The dashboard will combine current real-time clinical HIE data with MaineCare’s claims data. This is the first test of Maine’s HIE to support a “payer” using clinical EHR data.

HIN Objective 5- HIN will provide patients with access to their HIE medical record by connecting a provider’s “patient portal” to the HIE. The patient will access the HIE record via a “blue button” in their local patient portal environment.

Strengthen Primary Care	Integrate Physical & Behavioral Health	Centralize Data and Analysis	Engage People and Communities
HIN Objective 1	HIN Objective 2	HIN Objective 1	HIN Objective 5
HIN’s Health Information Exchange (HIE) data will support both MaineCare and provider care management of ED and inpatient utilization by sending automated emails to care managers to notify them of a patient’s visit along with associated medical	HIN will select 20 qualified Behavioral Health Organizations to provide \$70,000 each towards their EHR investments including their ability to measure quality	HIN’s Health Information Exchange (HIE) data will support both MaineCare and provider care management of ED and inpatient utilization by sending automated emails to care managers to notify them of a patient’s visit along with associated medical record	HIN will provide patients with access to their HIE medical record by connecting a provider’s “patient portal” to the HIE. The patient will access the HIE record via a “blue button” in their local patient portal environment.

record documents		documents	
	HIN Objective 3	HIN Objective 4	
	Connect behavioral health providers to HIN's Health Information Exchange	HIN will provide MaineCare with a web-based analytics tool referred to as a "dashboard." The dashboard will combine current real-time clinical HIE data with MaineCare's claims data. This is the first test of Maine's HIE to support a "payer" using clinical EHR data.	

E6b5. Maine CDC

The Maine Center for Disease Control and Prevention (Maine CDC), an office of the Maine Department of Health and Human Services (DHHS), is responsible for providing essential public health services that preserve, promote, and protect health.

Maine CDC SIM Objectives:

Maine CDC Objective 1- Implementation of the National Diabetes Prevention Program (NDPP)

Maine CDC Objective 2- Community Health Workers Pilot Project

Strengthen Primary Care	Integrate Physical & Behavioral Health	Develop New Workforce Models	Develop New Payment Models	Centralize Data and Analysis	Engage People and Communities
		Maine CDC Objective 2	Maine CDC Objective 1		Maine CDC Objective 1
		Community Health Workers Pilot Project	Implementation of the National Diabetes Prevention Program (NDPP)		Implementation of the National Diabetes Prevention Program (NDPP)
					Maine CDC Objective 2
					Community Health Workers Pilot Project

E6b6. Daniel Hanley Center for Health Leadership

The Daniel Hanley Center for Health Leadership has been selected, through a competitive bidding process, to implement the SIM Leadership Program, which includes 16 deliverables. The Daniel Hanley Center for Health Leadership will staff the Advisory Committee, drawing upon your own considerable experience and expertise to ensure that this ambitious set of goals is achieved.

Established in 2002, the Hanley Center is an independent statewide nonprofit focused on building a culture of greater trust and collaboration in Maine's health sector. Well over 500 healthcare professionals have participated in the Center's intensive leadership programs over the past eight years. For more information, visit www.hanleyleadership.org and www.healthleadershipmaine.org.

E6c. SIM Subcommittees

E6c1. Payment Reform Subcommittee Charge:⁴³

The SIM Subcommittee on Payment Reform will provide guidance and oversight to those aspects of Maine's State Innovation Model project that support the development and alignment of new payment models. The subcommittee will also assist in ensuring the coordination of the range of SIM-sponsored efforts that impact payment reform. Specifically, the Payment Reform Subcommittee will help guide the SIM work related to value-based insurance design; work around the identification and reporting of total cost of care, including behavioral health care; an Accountable Care Organization learning collaborative facilitated by the Maine Health Management Coalition; and the development and implementation of alternative, innovative payment models. The subcommittee will develop consensus on core measures sets for ACO performance and will assist in guiding the claims based analytics and performance measures used for public and provider reporting, including payment reform. This subcommittee will also be concerned with efforts to educate and engage the public around issues related to payment reform.

Lead Organization: Maine Health Management Coalition

E6c2. Delivery System Reform Subcommittee Charge:⁴⁴

The Maine SIM Delivery System Reform Subcommittee advises on SIM activities related to the scope of delivery system improvements, ensuring that the SIM governance structure is informed on best practices and approaches to accomplish the SIM mission and vision, and identify key dependencies from the SIM Subcommittees for Payment Reform and Data and Analytics Infrastructure. The SIM Delivery System Reform Subcommittee will ensure the coordination and comprehensiveness of key system delivery reform deliverables including, but not limited to, the

⁴³ Item is Hyperlinked to Subcommittee Member Roster

⁴⁴ Item is Hyperlinked to Subcommittee Member Roster

Learning Collaboratives for Primary Care and Behavioral Health, initiatives for Workforce Development, and supportive services provided through public health and community entities, in order to accomplish the strategic objective to *“support accountable and integrated patient-centered primary care in order to realize improved quality of care and service while positively impacting health outcomes, population health and cost.”*

Lead Organization: Maine Quality Counts

E6c3. Data Infrastructure Subcommittee Charge:⁴⁵

The SIM Data Infrastructure Subcommittee (DIS) is a multi-stakeholder public/private group of health information technology (IT) leadership and professionals.

The DIS provides recommendations for the identified needs of the Delivery System Reform and Payment Reform Subcommittee, as well as any SIM partner, related to IT infrastructure and capabilities necessary to operationalize the State Innovation Model objectives.

Results and recommendations will consider both short and long term sustainability of the SIM goals and final recommendations reached in consensus between the subcommittees involved will be reported to the SIM Steering Committee.

Lead Organization: HealthInfoNet

E6c4. Evaluation Subcommittee Charge:⁴⁶

The Maine SIM Evaluation Subcommittee will provide strategic oversight and guidance to the design and implementation of project evaluation, performance reporting, continuous quality improvement (CQI), and evaluation dissemination activities for Maine's SIM project. The Subcommittee will also support the development of local evaluation infrastructure as part of a sustainable research collaborative designed to build on the effectiveness of SIM models.

Lead Organizations: State of Maine/DHHS/Office of Continuous Quality Improvement and the Lewin Group

E6d. Additional SIM Focus Areas

E6d1. Data Analytics and Reporting

Data Analytics and Reporting is crucial to improving Maine’s healthcare system, and it serves as the backbone for all the quality improvement and payment reform efforts currently underway in Maine. Good data helps providers identify strategies that are successful or struggling, and it helps them to allocate resources to the right places in order to improve patient care and lower costs. Good data also helps consumers find and choose high quality health care providers, and creates competition in the marketplace that drives improvement for everyone.

Under the SIM award, three types of reports will be enhanced and made available to stakeholders engaged in quality improvement and cost containment efforts: primary care reports, system reports and public reports.

E6d2. Health Information Technology (HIT)

⁴⁵ Item is Hyperlinked to Subcommittee Member Roster

⁴⁶ Item is Hyperlinked to Subcommittee Member Roster

Health Information Technology is an important building block of a high functioning healthcare system, and developing a comprehensive, integrated HIT network will be an integral piece of the SIM work. Widespread use of HIT within the health care industry will improve the quality of healthcare, prevent medical errors, reduce healthcare costs, increase administrative efficiencies, decrease paperwork, and expand access to affordable health care. The MaineCare Meaningful Use Program's data and reports have helped inform the work of the SIM grant and improved outreach and education to providers and citizens. Their work will continue to be a key HIT component of the SIM grant.

E6d3. Consumer Engagement

A large portion of the State Innovation Model work is devoted to reforming the way in which we deliver and pay for health care, but just as important is the work aimed at engaging consumers. As the end-users of our healthcare system, it is crucial that patients are aware and supportive of the changes taking place. To facilitate this, the SIM work includes a number of initiatives aimed at communicating the changes that are happening and providing pathways for consumers to have their voice

E6e. SIM Pillar Strategies

E6e1. SIM Strategy 1: Strengthen Primary Care

Strengthen Primary Care Objectives:

- **Provide training to primary care practices serving youth and adults with Autism Spectrum Disorder and Intellectual Disabilities**
- **Provider Claims Information Portal**
- **MaineCare ED and Inpatient Notification Project**
- **Provide Practice Reports**
- **MaineCare Clinical Dashboard**
- **Implement MaineCare Accountable Communities Shared Savings**
- **ACO Initiative**
- **QI Support for Patient-Provider Partnerships**

A strong primary care system is foundational to improving the quality and lowering the cost of healthcare in our state. Primary care doctors play a leading role in managing patients' health and coordinating their care with hospitals and specialists. When primary care doctors have the tools and resources to do their job effectively they are able to keep patients healthy and reduce the need for costly emergency care down the road.

SIM test year one saw many capabilities developed that will strengthen primary care practices across the State of Maine, more effectively enabling these practices to deliver the proactive care to their patient populations that will help Maine to achieve the triple aim. Some of the capabilities that were developed as a result of SIM are as follows:

E6e1a. Implement MaineCare Accountable Communities

Through Accountable Communities, MaineCare will engage in shared savings arrangements with provider organizations that, as a group, coordinate and/or deliver care to a specified patient population. Accountable Communities that demonstrate cost savings, as well as the achievement

of quality of care standards, share in savings generated under the model. This initiative will be offered statewide as a Medicaid State Plan option.

Accountable Communities will result in such improvements as:

- Reductions in inpatient readmissions
- Less non-emergent Emergency Department use
- More effective use of Electronic Medical Records and real-time data through Maine's Health Information Exchange
- Increased investment in care management for members with chronic conditions, and more emphasis on preventive care

Accountable Communities will achieve the triple aim of better care for individuals, better population health, and lower cost through four overarching strategies:

- Shared savings based on quality performance- Accountable Communities will benefit from a Value-Based Purchasing strategy that supports more integrated and coordinated systems of care.
- Practice-level transformation- Accountable Communities will align with and build on the principles of Maine's multi-payer Patient-Centered Medical Home (PCMH) Pilot and MaineCare Health Homes Initiatives.
- Coordination across the continuum of care- Accountable Communities will ensure the coordination of primary, acute, and behavioral health care, as well as long-term services and supports. This includes leveraging the Maine Department of Health and Human Services' existing investment in care coordination for members with chronic conditions, behavioral health needs, and long term services and supports needs.
- Community-led innovation- Local health care needs, resources, and solutions will drive Maine's Accountable Communities. While each Accountable Community will meet baseline criteria, report on core quality measures, and be responsible for the cost of a set of core services, they will also be encouraged and afforded flexibility to structure services and solutions that fit locally-identified priorities and context.

Integration of the MaineCare Meaningful Use Program will be used to leverage opportunities and improve health outcomes through these communities.

E6e1b. Health Home Learning Collaborative

The Patient Centered Medical Home/Health Home Learning Collaborative continues to progress with success. In year one, 1,211 providers were included, along with 6 payers, impacting more than 700,000 beneficiaries across the State. Among the accomplishments in SIM Year One were: 1) rolling in 102 new single payer (Medicaid) primary care practices to the Learning Collaborative, including performing on-site practice assessments, focused support and tracking for achieving NCQA Medical Home recognition, and orientation sessions for them on the HH requirements and 10 Core Expectations; 2) convening several large face-to-face Learning Session with all the PCMH and HH practices, now totaling about 177 primary care practices, to explore their transformation with national experts and network with their colleagues on best

practices. 3) succeeding in collecting deliverables and reporting requirements from the practices as defined in their participation expectations; and 4) meeting and in many cases surpassing our Health Home Learning Collaborative quarterly accountability targets. We were pleased with the results from year one of the SIM grant, and have successfully expanded the medical home movement in Maine by supporting the HH Initiative, and as of January 2015 project that we will have nearly tripled the size of the PCMH/HH Learning Collaborative to include well over 200 primary care practices. We are also learning important lessons about how best to support the single payer HH practices in accomplishing their requirements and transforming care in the delivery system while they are still working primarily in the challenging environment of a fee-for-service model. By maximizing the positive, supportive relationships and technical assistance provided through the Learning Collaborative, we can use the discipline of quality improvement to hone in on the most difficult areas for the practices to ‘move the needle’ and provide customized approaches to facilitate their ability to provide high quality, patient centered primary care.

As of FY15Q3, SIM work to strengthen primary care continues on track, with several notable achievements. Maine Quality Counts (QC) continued to provide support to approximately 160+ primary care practices participating in the MaineCare Health Homes (HH) initiative and the HH Learning Collaborative. QC Quality Improvement Specialists continue to work directly with HH practices to implement the HH “Core Expectations” outlining key changes for practice transformation. HH Primary Care Practice Teams receive targeted quality improvement support and developed action plans to further strengthen care management services, access to care, patient engagement, and implementation of substance abuse screenings and developmental/autism screening.

E6e1c. MaineCare Notification Project /Emergency Room and Inpatient Notifications

Currently in 2015, MaineCare Care Managers receive Emergency Department (ED) and inpatient discharge summary reports for their members from the treating hospital via fax as requested. HealthInfoNet (HIN) is automating this process between the hospitals and MaineCare, on the hospitals behalf, using the Health Information Exchange. HIN is providing MaineCare Care Managers real-time electronic "notifications" using secure email of these events of care. Additional functionalities are being built to assure that this new electronic process creates a more efficient workflow for both the hospital and MaineCare staff while supporting MaineCare member's best possible care.

E6e1d. MaineCare Clinical Dashboard

HealthInfoNet (HIN) has developed and will provide a "Clinical Dashboard" to MaineCare using their member's information available in the Health Information Exchange (HIE). The goal is to make predictive scores, using the HIE clinical data available to MaineCare as a payer to support program and policy development related to population health efforts.

As of FY15Q3, HIN has delivered the initially scoped dashboard tool to MaineCare, which has begun the process of training staff and providing feedback. When the dashboard is completed it

will combine current real-time clinical HIE data with MaineCare's claims data. This will be the first test of Maine's HIE to support a payer using clinical electronic health record data.

E6e1e. Provider Portal- Primary Care Practice Access to Claims Data through Portals

By the end of SIM Test year one, there were more than 300 individual claims portals in existence deployed in practices across the state. Throughout the year, the Maine Health Management Coalition worked to promote and disseminate the patient portals, as well as explore new ways to leverage existing work across other payer data. As work continues into SIM Year Two on AC attribution methodology, SIM will be exploring ways to unify attribution processes where possible for use in future portals.

As of 2015, one of the benefits of having an all payer claims database in Maine is the ability to offer healthcare providers an in-depth look at the makeup of their patient populations. Under the Maine SIM award, the Maine Health Management Coalition has been contracted to build secure portals for providers to log in and examine claims data. This data will allow providers to allocate resources at their practice appropriately, and to target struggling patients that may need additional support.

E6e1f. Provider Practice Reports - Primary Care Practice Reports

Practice reports, like the provider portal, offer healthcare providers valuable insight into how well their practice is performing on key cost and quality metrics. The reports give providers insight into which areas they are performing well in, and which areas are in need of improvement.

E6e1g. Primary Care Practice Training in Intellectual and Developmental Disabilities

The process of refining the number and type of providers receiving the I/DD training continued into SIM Test Year Two. A contract for services was developed and awarded at the end SIM Year One with Maine's Developmental Disabilities Council, an organization experienced with working with workforce training for the I/DD population.

As of FY15 Q3 notable progress has been by the Maine Developmental Disabilities Council (MDDC), whose Developmental Disabilities (DD) Nurse Health Project is working to improve the care of individuals with DD. Specifically, the council has begun to focus their efforts on training caregivers to recognize pain behaviors in clients that have trouble verbalizing their pain. Through a guided curriculum, direct support professionals, guardians, case managers and physicians learn common reasons individuals with DD act out in negative ways when they are experiencing pain. Recognizing these behaviors will help those treating individuals with DD to provide more compassionate care. Several organizations, including Maine Quality Counts, CPI Inc., and the Maine Medical Association collaborated on the training, and additional stakeholders are being brought on board to develop a technical assistance application for phones. This "app"

will help anyone caring for individuals with DD with things like medication management, best practices, behavior modifications and resources for patients and families.

E6e1h. Patient Portal Pilot

HealthInfoNet will partner with one Health Information Exchange (HIE) health care organization to provide their patients with access to their statewide Health Information Exchange (HIE) record. The pilot site must be able to connect their current "Patient Portal" to the HIE to allow patients to download a medical record summary document from the HIE known as the "Continuity of Care Document" (CCD).

E6e2. SIM Strategy 2: Integrate Physical and Behavioral Health

Integrate Physical and Behavioral Health Objectives:

- **Implement MaineCare Behavioral Health Homes Initiative**
- **Behavioral Health HIT Reimbursement Grants**
- **Connect Behavioral Health to the Health Information Exchange**
- **Provide QI Support for Behavioral Health Homes Learning Collaborative**
- **Provide Learning Collaboratives for MaineCare Health Homes**

Behavioral health is increasingly being recognized as a vital piece of high quality primary care. Healthcare providers understand that in order to keep patients healthy, equal attention needs to be given to both body and mind. The following SIM activities are being undertaken to strengthen the ties between physical and behavioral health in order to provide Maine patients with comprehensive care:

E6e2a. Implement Behavioral Health Homes Initiative

Behavioral Health Homes were implemented on April 1, 2014, an unprecedented arrangement in the State of Maine, the Department provides monthly reimbursement to community mental health agencies qualified as BBHOs, with the goal of integrating physical and behavioral health care for adults with Serious Mental Illness and Children with Serious Emotional Disturbance. In Maine, 24 community-based mental health agencies at 60 sites partnered with primary care Health Home practices in order to integrate care for complex populations to achieve improved physical and mental health outcomes. Members enrolled in this service receive integrated, intensive care management of mental and physical health needs; assistance with transitions of care between residential, community-based, and/or hospital settings; peer supports; and other services. BHHOs have incorporated two new roles to their team-based approach to care to provide this service: the nurse care manager and the peer/family support coordinator. BHHOs also used an electronic portal developed by MaineCare which provided claims based data to guide teams in population management and risk stratification. In the portal, BHHOs were able to see aggregate quality metrics on their population served as well as drill down to data individual data. For example, one BHHO client had 69 emergency department visits prior to BHHO services and one visit post BHHO services, which was shown through portal data.

Although the State Plan Amendment was not approved during SIM's first year, the approval was received on December 17th 2014. Behavioral Health Home (BHH) enrollment has fluctuated, but appears to be trending upward. However, the enrollment goal in test year one of 8,500 people served was not attained. Just under 2000 people are enrolled in BHHO services. Approximately 70% of those receiving BHHO services are adults BHH leadership is developing strategies to increase the number enrolled in BHH. A key goal in the second year was to increase the number of enrolled lives in the behavioral health homes.

Behavioral Health Homes will result in such improvements as:

- Vastly improved coordination between mental health and physical health providers, including BHH organization use of Electronic Health Records and the Health Information Exchange;
- Reductions in inpatient readmissions;
- Less non-emergent Emergency Department use;
- Improved self-management of diabetes and other chronic conditions;
- Provision of peer and family supports.

As of FY 2015 Q3, MHMC's Pathways to Excellence (PTE) Crossover Subcommittee—which is charged with developing communication strategies between the PTE Clinicians and PTE Behavioral Health Steering Committees and developing metrics for public reporting that support behavioral health integration with primary care have endorsed an icon that will help patients identify primary care practices that are working to Integrate behavioral health specialty services. The icon has been approved for publication by the MHMC Board of Directors and will be available on the GetBetterMaine website beginning in January 2016.

E6e2b. Provide Quality Improvement Support for Behavioral Health Homes Learning Collaborative

In 2014 the BHH Learning Collaborative continued to expand its outreach to and interaction with BHHOs in order to help the 24 BHHOs achieve the 10 core expectations and meet Learning Collaborative participation requirements of Learning Session attendance and participation in monthly webinars. Key concepts addressed by the Learning Collaborative include population management and risk stratification; the role of the nurse care manager and the peer/family support specialist on the BHHO team; and strategies for integrating physical and mental health as well as enhancing the involvement of families and peers BHH LC staff, also conducted site assessments for each BHHO and provided this information to the BHHOs for practice improvement and action planning and to the Office of MaineCare Services.

Rich discussion from cross-sector stakeholders continued to inform Learning Collaborative work. Two groups advised the Learning Collaborative efforts: The Behavioral Health Home Working Group and the Quality Counts Behavioral Health Committee. An Ad Hoc Committee: the Consumer/Family Peer Group advises the BHH Working Group on strategies to incorporate consumer and family perspective into BHH LC activities and educational content. In addition, a team of consultant psychiatrists and a consultant behavioral health organization and two

consultant consumer organizations advise the BHH LC on its outreach, activities, quality improvement, and educational content.

Key BHH LC accomplishments of 2014:

- 96 percent of Behavioral Health Home Teams participated in three Learning Sessions held in 2014.
- BHH LC webinars exceeded the 50% participation goal set at the launch of the BHH LC, with an average participation rate for the 8 webinars held in 2014 of 71%. Total webinar participation for 2014 254 people.

Currently in 2015, Maine Quality Counts continues to support the BHH LC with the addition of 3 new BHHOs for a total of 27 BHHOs. The Learning Collaborative continues to offer practitioners the opportunity to come together in a structured way to learn from national, state, and local experts and from each other to improve the quality of services they provide. The BHH Learning Collaborative focuses on evidence-based best practices to improve the integration of behavioral and physical health services to improve care for adults with Serious Mental Illness (SMI) and children with Serious Emotional Disturbance (SED). Additionally, the Collaborative seeks to identify best practices that can help BHHOs enhance coordination of care and bring about improvements and efficiencies that will help to decrease costs. The Learning Collaborative will incorporate provider and consumer perspectives and will present evidence-based and emerging best practices to participants for shared learning. Participants will be involved in a series of meetings to learn about best practices in chosen areas, quality improvement methods, and change ideas, and to engage in peer learning where participants share experiences on what has worked in their settings. Quality Counts will offer three day-long Learning Sessions per year as well as conduct site visits to assess baseline; hold webinars to share best practices and innovative approaches; and provide technical assistance as needed.

E6e2c. Provide Learning Collaborative for MaineCare Health Homes

Maine Quality Counts (QC) provides quality improvement support to 80 primary care practices participating in the MaineCare Health Homes (HH) initiative by providing direct outreach and support, as well as bringing these HH practices into the PCMH Learning Collaborative. This support includes conducting a baseline onsite assessment of each HH practice to assess the degree to which they have implemented the PCMH Core Expectations, as well as ongoing support provided by a QC Quality Improvement Specialist. The PCMH/HH Learning Collaborative also includes two to three day-long central Learning Sessions, as well as two regional meetings annually that bring practice teams together to learn from national and local experts and to share best practices on implementing the PCMH/HHs model of care.

As of FY15Q3, SIM work to strengthen primary care continues on track, with several notable achievements. Maine Quality Counts (QC) continues to provide support to approximately 160+ primary care practices participating in the MaineCare Health Homes (HH) initiative and the HH Learning Collaborative. QC Quality Improvement Specialists continue to work directly with HH practices to implement the HH “Core Expectations” outlining key changes for practice transformation. HH Primary Care Practice Teams receive targeted quality improvement support

and developed action plans to further strengthen care management services, access to care, patient engagement, and implementation of substance abuse screenings and developmental/autism screening.

E6e2d. Behavioral Health HIT Reimbursement Grant - Behavioral Health Homes Electronic Health Records

In May of 2014 the Behavioral Health Information Technology Reimbursement Initiative was launched with the initial 20 BH organizations from across the state of Maine. HealthInfoNet (HIN) uses SIM funding to support behavioral health organizations with reimbursements towards improving Electronic Health Records technology and participation in health information exchange (HIE). HIN is also supporting behavioral health organizations in their measurement of quality of care using their interoperable data. The goal is to add up to 20 new behavioral health organizations to HIN's HIE by 2016. Of the participating organizations all regions of the state are represented: South, East/North, and Central/West. Approximately 90,000 patients are served annually by the participating organizations. Milestone payments were paid out by the end of the 3rd quarter, September 30th, 2015, in the total amount of \$590,000 . The initiative holds required monthly webinar's and weekly technical calls to provide milestone information and education towards achieving the milestones.

E6e2e. Behavioral Health Homes to Health Information Exchange

HealthInfoNet aims to connect up to all twenty Behavioral Health organization's medical records systems to begin to collect data to incorporate into the current HIE which has been limited to non-behavioral health data. HIN has seven active BH HIE connections in place. The first BH EHR vendor completed bidirectional HIE testing and completed production validation in the 2nd quarter of year 2 to go-live with BH data sharing for the first time in Maine. As the sites participating in the Reimbursement Initiative are connected and begin to share data via a bidirectional VPN connection, the accountability targets of 15 BHH connected to the HIE will be accomplished in SIM test year 2.

As of FY15 Q3, in supporting the work of BHH organizations connecting to the HIE, MaineCare has reported that they are in the process of providing quality data to BHH organizations that will be accessible through the provider portal. They have also begun to work on a BH workforce development sustainability plan and a series of internet modules aimed at helping BH providers engaged in the work.

E6e3. SIM Strategy 3: Develop New Workforce Models

Develop New Workforce Models Objectives:

- **Develop and implement Physical Health Integration workforce development component to Mental Health Rehabilitation Technician/Community (MHRT/C) Certification curriculum**
- **Provide QI Support for Behavioral Health Homes Learning Collaborative**

- **Provide Learning Collaboratives for MaineCare Health Homes**
- **Public Reporting for Quality Improvement and Payment Reform**
- **Community Health Workers Pilot**

One of the primary drivers of high costs and poor patient outcomes in our healthcare system is the absence of coordinated preventative care. All too often we are treating health problems as they arise instead of dealing with them before they become an issue. To address this problem, SIM work focuses significant resources on expanding the ability of providers to reach and serve patients. It will bolster efforts like Maine Quality Counts' Health Homes initiatives (pillar 2), the Maine Health Management Coalition's transparency initiatives (pillar 4), and Maine CDC's Community Health Workers (CHWs) Project:

E6e3a. Community Health Workers Pilot

Maine's Community Health Worker (CHW) initiative will develop a system of CHWs as part of Maine's transformed healthcare system. CHWs engage underserved populations by:

- Providing culturally appropriate health education and outreach;
- Linking individuals, communities, healthcare providers and social services;
- Assuring people can access the services they need.

Research demonstrates that CHWs help improve health outcomes and reduce costs. Five SIM-funded CHW pilots will:

- Demonstrate the value of integrating CHWs into the health care team;
- Provide models for state-wide replication;
- Build a core group of experienced CHWs who can provide leadership for ongoing development of the system.

As of FY2015 Q3, The Maine CDC reported that their Community Health Worker (CHW) Pilot Projects are in full swing, with all four sites actively engaging clients and patients, and reporting out on progress and challenges during their monthly mentoring calls. At one site, participants highlighted the CHWs' effectiveness at improving cancer-screening rates, touting a 6% improvement in colorectal cancer screening just in their second quarter. This early success is an encouraging sign that CHWs can help to improve patient care.

E6e3b. Provide QI Support for Behavioral Health Homes Learning Collaborative

Maine Quality Counts will support a Learning Collaborative for 27 Behavioral Health Home organizations. The Learning Collaborative will offer practitioners the opportunity to come together in a structured way to learn from national, state, and local experts and from each other to improve the quality of services they provide. The BHH Learning Collaborative will focus on evidence-based best practices to improve the integration of behavioral and physical health services to improve care for adults with Serious Mental Illness (SMI) and children with Serious Emotional Disturbance (SED). Additionally, the Collaborative will seek to identify best practices

that can help BHH organizations enhance coordination of care and bring about improvements and efficiencies that will help to decrease costs. The Learning Collaborative will incorporate provider and consumer perspectives and will present evidence-based and emerging best practices to participants for shared learning. Participants will be involved in a series of meetings to learn about best practices in chosen areas, quality improvement methods, and change ideas, and to engage in peer learning where participants share experiences on what has worked in their settings. Quality Counts will offer three day-long Learning Sessions per year as well as conduct site visits to assess baseline; hold webinars to share best practices and innovative approaches; and provide technical assistance as needed.

E6e3c. Public Reporting for Quality Improvement & Payment Reform

We know that what gets measured gets improved, so in an effort to strengthen the quality and lower the cost of healthcare in Maine, the State Innovation Model award will provide additional funding to develop new quality and cost metrics that will be publicly reported on the Maine Health Management Coalition's website, www.getbettermaine.org. Patients will be encouraged to use the information to find top performing doctors and hospitals, and employers will be encouraged to use the information in their benefit designs.

E6e3d. Leadership Program

The State Innovation Model Leadership Program is vital element of the overall SIM initiative. Its goals are to:

- Establish a shared vision and a plan for sustainably providing leadership opportunities to develop the skills of health care teams (including clinicians and administrators) needed to support the accomplishment of SIM Triple Aim goals to improve health and health care in Maine; and,
- Build the capacity of health care teams (including clinicians and administrators) to successfully manage and sustain the transformational changes occurring in our health care system.

With the guidance of the SIM Leadership Program Advisory Committee, several major initiatives will take place from the spring of 2015 through the fall of 2016. These include a Leadership Visioning Forum and planning process that will pull together health and healthcare CEOs and other key decision-makers to develop the shared, long term vision for leadership development across Maine's health sector. Beginning in September of 2015, a series of workshops will prepare team leaders and their teams to manage change and stay resilient during a period of unprecedented systems transformation here in Maine.

E6e4. SIM Strategy 4: Support Development of New Payment Models

Support Development of New Payment Models Objectives:

- **Stimulate Value-Based Insurance Design (VBID)**
- **Implement MaineCare Accountable Communities Shared-Savings**

- **ACO Initiative**
- **Provide Practice Reports**
- **Provide Learning Collaboratives for MaineCare Health Homes**
- **Public Reporting for Quality Improvement and Payment Reform**

In today's fee-for-service payment system, doctors and hospitals are paid based on the amount of services they provide, not for making patients healthier. As part of the SIM initiative, the State is seeking to change this model to align payment with improved patient outcomes. The following describes work being undertaken to promote alternative payment systems:

E6e4a. Public Reporting for Quality Improvement & Payment Reform

In SIM Year one, 1,933 providers and 228 provider organizations were represented in public reporting activities, and a major accomplishment of the SIM Year one was gaining a recommendation from both the MHMC Physicians and Systems Pathways To Excellence committees to publicly report on the proposed Total Cost of Care/Resource Use index measures. This is an important step forward in terms of enhancing transparency at both the practice and practice group level in Maine. The work of the Healthcare Cost work group also proceeded smoothly with the group identifying its top three priorities to focus on during its first phase of study: price, infrastructure and patient engagement. The Pathways To Excellence Behavioral Health group, newly formed in SIM year one, was also established and make great progress through the first year; displaying enthusiasm and drive to get quickly develop its first measures for public reporting. Similarly, the Standard Measures Alignment subgroup continued to progress in its work and picked up the pace throughout the year. Additionally, we have observed a growing publicly shared view on the part of Maine payers regarding their interest in aligning their own metrics with those publicly reported by the Coalition, and we had been "saving" the conversation around a cost measure for later in this workgroup process. The recent recommendation of publication of the Total Cost and Resource Use Indices by the PTE groups now provide the basis for a much easier conversation about this within the context of the measure alignment workgroup, and is considered a major breakthrough during year one for public reporting and perhaps, payment reform as a whole.

Work in support of MaineCare's Accountable Communities initiative has progressed throughout the project, with MHMC able to replicate Deloitte's attribution methodology enabling the provision of analytic support that MaineCare requires for this effort. The ultimate goal for this objective is to, through public reporting, influence market forces and move a total of 67% of Maine's population to an alternative payment arrangement. In 2013, we reported 85,000 lives covered under alternative payment arrangements. A survey conducted at the end of Year One indicates a minimum of 215,000 such lives. This count does not include enrollees in two of the major health plans operating in the Maine market, nor any MaineCare enrollees.

Currently in 2015, we know that what gets measured gets improved, so in an effort to strengthen the quality and lower the cost of healthcare in Maine, the State Innovation Model award will provide additional funding to develop new quality and cost metrics that will be publicly reported on the [Maine Health Management Coalition's](http://www.getbettermaine.org) website, www.getbettermaine.org. Patients will be

encouraged to use the information to find top performing doctors and hospitals, and employers will be encouraged to use the information in their benefit designs.

E6e4b. Provide Quality Improvement Support for Behavioral Health Homes (BHH) Learning Collaborative

Maine Quality Counts will support a Learning Collaborative for 27 Behavioral Health Home organizations. The Learning Collaborative will offer practitioners the opportunity to come together in a structured way to learn from national, state, and local experts and from each other to improve the quality of services they provide. The BHH Learning Collaborative will focus on evidence-based best practices to improve the integration of behavioral and physical health services to improve care for adults with Serious Mental Illness (SMI) and children with Serious Emotional Disturbance (SED). Additionally, the Collaborative will seek to identify best practices that can help BHH organizations enhance coordination of care and bring about improvements and efficiencies that will help to decrease costs. The Learning Collaborative will incorporate provider and consumer perspectives and will present evidence-based and emerging best practices to participants for shared learning. Participants will be involved in a series of meetings to learn about best practices in chosen areas, quality improvement methods, and change ideas, and to engage in peer learning where participants share experiences on what has worked in their settings. Quality Counts will offer three day-long Learning Sessions per year as well as conduct site visits to assess baseline; hold webinars to share best practices and innovative approaches; and provide technical assistance as needed.

E6e4c. Accountable Communities

Significant progress has been made in implementing the Accountable Communities (AC) program. MaineCare expected Round 1 participation of 5 ACs covering 25,000 lives; instead participation is 4 ACs covering 30,000. The contracting process took longer than expected, with the contracts not being signed during SIM Year 1, but with the contracts' start date being August 1, 2014. The Department has provided ACs with all required monthly data reports since August and has received extremely positive feedback from the ACs.

As of FY2015 Q3, strong progress is continuing to be made by MaineCare to implement its Accountable Communities (AC) Shared Savings ACO initiative. The department reported that all four AC contracts are now in place, and work with USM's Muskie School of Public Service to launch the AC portal is well underway. Already, the Maine Health Management Coalition (MHMC) has developed and delivered monthly utilization reports and quarterly quality reports, and claims downloads have been implemented. During this quarter MHMC also developed and delivered the quarterly Total Cost of Care reports to the ACs, and they have been working extensively with the Department of Health and Human Services and Deloitte to fully operationalize the Year 2 benchmark TCOC Data Books, which round out the data reports required by MaineCare under the AC contract. Looking towards year two of the Accountable Communities initiative, the Office of MaineCare Services, Deloitte, and the MHMC met to develop the year 2 benchmark reports. OMS has also begun work on an improvement plan for contracting with round II ACs that will include final contracts as part of the request for

applications. It is hoped that including these contracts will help to mitigate delays experienced in round I contracting.

Looking towards year two of the Accountable Communities initiative, the Office of MaineCare Services, Deloitte, and the MHMC met to develop the year 2 benchmark reports. OMS has also begun work on an improvement plan for contracting with round II ACs that will include final contracts as part of the request for applications. It is hoped that including these contracts will help to mitigate delays experienced in round I contracting. The MHMC reported that it had delivered over 400 commercial and 358 MaineCare practice reports to primary care practices in Maine this quarter. The reports contain data on the practices' cost and quality, and they allow them to compare their performance against their peers' in the state. Coalition staff are engaging with practice owners/PHOs to help them understand and effectively utilize the report data, and they are also working with Maine Quality Counts on their education efforts with practices around the reports.

Through the Maine Patient-Centered Medical Home (PCMH) Pilot, Maine Quality Counts continued to work with SIM leadership and partners this quarter to explore opportunities for further advancement in primary care payment reform. This work is being done to support and sustain an additional 100 Health Home (HH) practices in the state that have come on board this quarter.

E6e4d. Stimulate Value Based Insurance Design (VBID)

One of the reasons the US healthcare system is the most expensive in the world is because our current "fee-for-service" system incentivizes high volume, high cost care. At most hospitals and medical practices around the country, doctors are paid based on the number of services provided, not for making patients healthy.

One way the State hopes to impact high healthcare costs is by changing the incentives in the market and aligning costs with the relative value of healthcare services. Value-Based Insurance Design is a form of health benefit design that provides incentives to consumers/patients that opt for care that is both high quality and low cost. It also incentivizes healthcare providers to choose lower cost care options when a range of equally effective approaches to care are available for a given patient.

To explore VBID in more detail and assess its potential for increasing healthcare value in Maine, the [Maine Health Management Coalition](#) (MHMC) convenes the VBID Workgroup. Facilitated by the MHMC's VBID Manager, the workgroup is charged with examining VBID examples around the country and identifying best practices in a value-based insurance design. They are also responsible for creating a means to rank insurance plans according to adopted VBID metrics, and encouraging Maine businesses to adopt the new benefit model.

The Value Based Insurance Design initiative included 9 payers representing more than 600,000 beneficiaries with a goal of 100,000 enrolled lives by the end of the SIM grant. In year one, the VBID workgroup reviewed and recommended adoption of a strategy for rating health plans with

regard to their use of value based design approaches; and these ratings have been published on the MHMC website (www.mehmc.org).

E6e4e. National Diabetes Prevention Program

The goal by the end of year one was for 5 provider organizations to participate in the NDPP, with an ultimate goal of 15 by the end of the grant. SIM did achieve the NDPP goal for year one. To support the organizations, training was held with the outcome of twenty new lifestyle coaches trained to support NDPP. Planning for a November NDPP forum to share information about NDPP with employers, providers, and payers also occurred. The forum included a partnership with the Maine Health Management Coalition, US Centers for Disease Control and Prevention, and American Medical Association. Partnering with the other SIM grant partners (MaineCare, MHMC, MQC, and HIN) provided opportunities to meet with work groups and their subcommittees. These work groups/subcommittees and their members have provided guidance on design and approach with payer/purchasers regarding NDPP and how to establish a sustainable structure for payment within VBID/ACO plan designs. Maine CDC is pleased with the opportunity that SIM has provided to the public health community in support of population health and strong community and clinical linkages well into the future. Being invited to participate in the various SIM work groups and subcommittees provides a unique opportunity to leverage the work of SIM for both the NDPP and CHW initiatives of Maine CDC. Important for sustainability is consideration of how future payment and delivery system reform initiatives will support these strategies and the affiliated workforces.

As of FY2015 Q3, The Maine CDC reported that their National Diabetes Prevention Program (NDPP) Project is on track for all tasks during the quarter. Program evaluation planning is underway, lifestyle coaches are being trained and deployed as planned for new and current programs, and the State of Maine has added NDPP coverage to their health plan design.

E6e5. SIM Strategy 5: Use Centralized Data & Analysis to Drive Change

Objectives:

- **Tracking Cost of Care**
- **MaineCare Clinical Dashboard**
- **Public Reporting for Quality Improvement and Payment Reform**

Data and analytics are an integral piece of the SIM work currently underway around the state. Robust data holds not only the potential to tell us how costs, utilization and quality vary around the state, but it can also help break down barriers between doctors and the patients they care for. Nearly every SIM objective has a foundation in data and analytics because we know that what gets measured gets improved. The following SIM activities are being undertaken to strengthen data and analytics in the state:

E6e5a. All Payer Claims Database

The MHDO is responsible for the security and protection of over one billion healthcare records which includes medical, pharmacy and dental claims data; hospital inpatient and outpatient encounter data for all encounters; hospital quality data specific to healthcare associated infections and nursing sensitive indicators; and hospital financial and organizational data. Every month the amount of data the MHDO is responsible for grows. Acceptable uses of MHDO Data include, but are not limited to, study of health care costs, utilization, and outcomes; benchmarking; quality analysis; and administrative or planning purposes. Many organizations in the State of Maine (and out) access the MHDO data for a variety of analysis. The release of MHDO data is defined in Chapter 120: RELEASE OF DATA TO THE PUBLIC.

Currently, MHDO is in the process of replacing this rule with an updated version which includes a new provision which would allow the MHDO to release individually identified healthcare data per the requirements in the proposed rule.

The addition of this new provision is a result of data requests for this type of information to support the data analytics for several key health care reform initiatives in the State of Maine. A law was passed by the Maine State Legislature to allow for the release of this level of data subject to a major substantive rule making process. This is one example of the MHDO's ability and authority to respond to the evolving needs of our data users. The way healthcare data is being used today is very different then the way it was used when the MHDO was first established in 1993.

The MHDO's governing statute provides broad authority for the agency to define and collect healthcare data-administrative and or clinical. Once the new data release rule is adopted the MHDO Board of Directors is prepared to address the next significant data need-the potential integration of healthcare claims and clinical data through a subcommittee of the MHDO board. The charge of this group is:

- Develop a proposed working definition of clinical data.
- Conduct an environmental scan on the current state of who is collecting and using clinical data; determine if there is value in the state collecting clinical data as defined by the subcommittee.
- Develop Use Case rationale.
- Report back to the MHDO board at TBD board meeting

With financial support through the Health Insurance Rate Review Grant Program provided from the Centers for Medicare & Medicaid Services (CMS) and the Center for Consumer Information and Insurance Oversight (CCIIO), the MHDO has enhanced the content, volume and display of health care cost and quality information on our new website www.comparemaine.org

The MHDO's governing statute requires the MHDO to publically report payments for services rendered by health care facilities and practitioners to residents of the State. The services presented must include, but not be limited to, imaging, preventative health, radiology and

surgical services and other services that are predominantly elective and may be provided to a large number of patients who do not have health insurance or are underinsured. The website must also be constructed to display prices paid by individual commercial health insurance companies, 3rd-party administrators and, unless prohibited by federal law, governmental payors

CompareMaine allows for the Comparison of Costs for 206 Procedures by Facility (162 facility groups comprising 237 facilities including hospitals, surgical centers, diagnostic imaging centers, labs & clinics) by the top 5 Health Insurance Companies (Aetna, Anthem, CIGNA, Harvard, Community Health Options) in the State as well as a combined state average. This website will continue to evolve over time. The next release of the site is scheduled for the second quarter of 2016 and will include a number of new procedures and enhancements to some of the functionality and language on the site.

E6e5b. Tracking Cost of Care

We know that there is significant variation in the cost of healthcare services around the state of Maine, but without transparent pricing information it is impossible for consumers and businesses to know which practices and hospitals are offering the most competitive rates. This lack of transparency, and thus lack of competition, is one of the primary drivers behind Maine's high healthcare costs.

To address the high costs and lack of transparency, the Maine Health Management Coalition will convene the Cost of Care Work Group. The Cost of Care Work Group is a multi-stakeholder group that will analyze health care cost drivers in Maine and identify actionable strategies to reduce health care costs while preserving or improving quality. The group will include purchasers, providers, health plans, and consumers, and will meet monthly.

Additionally, the Maine Health Management Coalition will produce a Healthcare Cost "Fact Book" that will be made available to the general public. The fact book will provide information regarding the cost of care in Maine and identify those areas of highest costs.

While this work is being carried out, the Coalition will hold periodic summit meetings of Chief Executive Officers from Maine's business community to brief them on the findings of the Cost of Care Work Group and Healthcare Cost Fact Book.

E6e5b1. Healthcare Cost Workgroup

All meetings are publicized on the Maine Health Management Coalition website, on the SIM website, and are also shared with the SIM Steering Committee, the Payment Reform Subcommittee, and the Accountable Care Implementation (ACI) Steering Committee. In addition, email invites are routinely sent to all persons on the workgroup's interested parties list, which numbers approximately 125 individuals. The group has identified price, infrastructure, and consumer engagement as their initial areas of focus, and participants have begun reviewing and discussing various price options for reducing healthcare costs, including transparency, reference pricing, bundled payments, and narrow networks. Working from this list of consensus-based priorities, the group – with the help of an expert facilitator– developed a recommendation for a voluntary cap on year over year growth in risk based contracts, tracking to Medical CPI. This recommendation was presented to a group of 52 attendees at the October 2014 CEO Summit. Informal feedback from this meeting indicated the intention of certain “pairs” of purchasers and

ACOs to implement this recommendation. Other, more formal feedback has been a bit more equivocal. Because the lead time on contracting is so long (businesses were already well into the process of negotiating coverage arrangements by the time of the Summit), adoption of this tactic will only be able to be documented in 2016. The Healthcare Cost workgroup has now begun to explore the issue of health care infrastructure, identifying potential areas where excess capacity might exist, as well as possible data needs.

E6e5b2. Healthcare Cost Data Book

The Healthcare Cost Data Book was compiled and produced, with dissemination beginning in Year One, Q4 and continuing into Q1 of Year Two. The book has been well received. It is available in electronic form on the Coalition's website. Hard copies of the book were distributed to key stakeholders, including all SIM governance members, key members of the Administration, key members of the Maine Legislature and representatives of CMMI. The book will be updated on a regular basis, with subsequent "editions" released every six months. Click [here](#) to view the latest release.

E6e5c. CEO Summit

In Q3, staff worked to develop topics and recruitment strategies for the CEO Summit and advanced efforts to find a keynote speaker and facilitator. The key note speaker for this event was Alan Gilbert, of GE's health imagination initiative. More than 52 individuals participated in the Summit; as evidenced by participant feedback, the event was well-received.

E6e5d. Accountable Community Work With MaineCare

Over the course of the project, the Coalition worked closely with MaineCare staff and the Department's consultants (Deloitte) to discuss and refine the Accountable Community methodology. This has necessarily been a very long and very detailed process, so as to ensure that the Department is entirely comfortable that the approach reflects its policy decisions. As this process unfolded, new issues of policy presented themselves. This required time for the Department to resolve, but leads to a better end product. Because of the time taken to work through this process, though, the time line for the Coalition's work on AC's was delayed. Similarly, as issues crop up in the future, the Coalition's work will necessarily be impacted as the Department works to resolve new questions. The Coalition is now producing monthly reports for AC practices as required.

E6e5e. Clinical Dashboard

HealthInfoNet (HIN) has developed and will provide a "Clinical Dashboard" to MaineCare using their member's information available in the Health Information Exchange (HIE). The goal is to make predictive scores, using HIE clinical data, available to MaineCare as a payer to support program and policy development related to population health efforts.

As of FY15Q3, HIN has delivered the initially scoped dashboard tool to MaineCare, which has begun the process of training staff and providing feedback. When the dashboard is completed it

will combine current real-time clinical HIE data with MaineCare's claims data. This tool is currently in the testing phases and is the first test of Maine's HIE to support a payer using clinical electronic health record data.

E6e5f. Public Reporting for Quality Improvement & Payment Reform

We know that what gets measured gets improved, so in an effort to strengthen the quality and lower the cost of healthcare in Maine, the State Innovation Model award will provide additional funding to develop new quality and cost metrics that will be publicly reported on the Maine Health Management Coalition's website, www.getbettermaine.org. Patients will be encouraged to use the information to find top performing doctors and hospitals, and employers will be encouraged to use the information in their benefit designs.

E6e5g. Provider Practice Reports

Practice reports, like the provider portal, offer healthcare providers valuable insight into how well their practice is performing on key cost and quality metrics. The reports give providers insight into which areas they are performing well in, and which areas are in need of improvement.

E6e5h. MaineCare Notification Project

Currently in 2015, MaineCare Care Managers receive Emergency Department (ED) and inpatient discharge summary reports for their members from the treating hospital via fax as requested. HealthInfoNet (HIN) is automating this process between the hospitals and MaineCare, on the hospitals behalf, using the Health Information Exchange. HIN is providing MaineCare Care Managers real-time electronic "notifications" using secure email of these events of care. Additional functionalities are being built to assure that this new electronic process creates a more efficient workflow for both the hospital and MaineCare staff while supporting MaineCare member's best possible care.

As of FY2015 Q3, after months of testing, the secure emails are now live in production are being distributed smoothly. The emails let care managers know when MaineCare patients have used inpatient or ED services, and they include information about the visit and associated medical record documents. The goal of these emails will be to better coordinate patient care to improve outcomes and avoid additional ED visits down the road.

E6e6. SIM Strategy 6: Engage People & Communities

Engage People & Communities Objectives:

- **Implementation of the National Diabetes Prevention Program (NDPP)**
- **Consumer Engagement and Education Regarding payment and system delivery reform**
- **QI Support for Patient-Provider Partnerships**
- **Community Health Workers Pilot Project**

Whether the State Innovation Model work underway focuses on creating a new database or an Accountable Care Organization, the purpose is ultimately to provide higher quality, more affordable healthcare to Maine's people and communities. As the end-users of the work being done, it is important that Maine people are being involved and that they understand the reasons for the changes taking place in the healthcare system. To that end, the State Innovation Model puts a strong emphasis on engaging people and communities.

E6e6a. Health Information Exchange - Patient Portal 'Blue Button' Pilot

The 12-month pilot between HIN and Eastern Maine Health System was launched in June 2014. The initial implementation work for the pilot was begun with a selected leadership team focused on patient portal implementation and patient engagement. The pilot work began with an ideal set of primary care practices with strong patient engagement activities already in place. As of the end of the pilot, over 500 patients accessed their HIE record in HIN.

As of FY2015 Q3, In addition to engaging consumers in the use of healthcare quality information, SIM is also engaging them to be active participants in their health by accessing and using their patient portals. HealthInfoNet's Blue Button pilot, which provides patients with access to their HIE medical record, has been successfully completed this quarter. Final lessons learned and pilot results will be provided once the final round of patient feedback is available, but so far patient, consumer and staff feedback has been very positive. The project exceeded engagement goals and has energized the health system's patient portal efforts at the pilot sites.

E6e6b. Community Health Workers Pilot

Community health workers can be an important bridge between providers and individuals to promote health, reduce disparities, and improve service delivery. Q3 of 2014 for the CHW Initiative was focused on readying activities for "CHW Pilot Site contract approval". Following the release of the CHWPP RFP were a number of preparatory activities that occurred and led up to the review of proposals for the CHW Pilot Projects, they included: a bidder's Conference (04/01/14), Publishing Questions and Answers specific to the CHWPP RFP (4/25/14), accepting Letters of Intent (05/02/14) and full proposal submissions (06/02/14). Review of the CHWPP proposals was completed during the week of June 16th by staff from Maine CDC and MaineCare. Contracts were completed with four organizations.

As part of building the infrastructure and sustainability of CHWs, a CHW Stakeholder Group was convened to inform the CHW Initiative and has met nine times since its inception in October of 2013. The group informs the CHW Initiative in the infrastructure and systems development work that parallels and complements the implementation of CHW Pilot Projects. Shared learning, development of guidance, networking and a focus on sustainability anchor the group in its work. Close to 100 individuals receive information regularly from the project and 30 members regularly participate in monthly meetings. The CHW Stakeholder Group has completed the following: CHW core roles and responsibilities, cross-walk of roles and responsibilities to skills and attributes of CHWs, and recommendations for recruitment of CHWs.

Currently in 2015, Maine's Community Health Worker (CHW) initiative will develop a system of CHWs as part of Maine's transformed healthcare system. CHWs engage underserved populations by:

- Providing culturally appropriate health education and outreach;
- Linking individuals, communities, healthcare providers and social services;
- Assuring people can access the services they need.

Research demonstrates that CHWs help improve health outcomes and reduce costs. Five SIM-funded CHW pilots will:

- Demonstrate the value of integrating CHWs into the health care team;
- Provide models for state-wide replication;
- Build a core group of experienced CHWs who can provide leadership for ongoing development of the system.

E6e6c. Community Engagement and Education Regarding Payment and DSR

The Coalition has engaged in outreach efforts to inform the public about efforts around payment reform, public reporting, and delivery system reform. A [video](#) explaining VBID has been produced and is now available on the Coalition's website. The Data Book served as a vehicle for outreach to a broad swath of the Maine public. The Coalition's annual conference served as a venue to spotlight issues central to SIM and generated a number of press pieces and interviews.

The MHMC also supports the Payment Reform Subcommittee, which is one of three subcommittees supporting SIM governance. This Committee chose to meet once every two months, alternating with meetings of the Coalition's ACI group, as many people serve on or are interested in the work of both committees. All efforts were made to ensure that members of the PRSC were kept up to date about and welcomed their participation in all relevant SIM activities.

Currently 2015, Engaging patients in payment and delivery system reform is crucial. As the end users of our healthcare system, patients will be the ones that ultimately accept or deny the changes taking place. Because some of the reforms might be construed as negative by patients, like the use of narrow networks in Value-Based Insurance Designs, the [Maine Health Management Coalition](#) will be spearheading a consumer engagement campaign to inform the public of what is changing and why it is important. They will produce videos, print materials, and will engage consumer advocates, [Area Agency on Aging](#) advisors, navigators, free care providers, brokers, human resource specialists, and Maine payer staff in trainings so that they better understand the changes taking place.

As of FY2015 Q3, The Maine Health Management Coalition (MHMC) has made progress engaging broader audiences in their work around payment and system delivery reform during the quarter by developing strategic partnerships with organizations around the state that are interested in aspects of their work. Through one partnership with the Bangor Regional Chamber of Commerce, the MHMC presented strategies for improving employee health and lowering costs to regional employers. Through another with David Ciullo, host of the HR Power Hour radio show, the MHMC was able to discuss its work around value-based insurance design

(VBID). Coalition staff were able to reach between six and seven thousand listeners on the radio show – many of whom are HR personnel that were previously unaware of VBID. MHMC also continues to make progress in its efforts to engage consumers with healthcare quality information this quarter. The Coalition’s Board of Directors approved a Total Cost Index display for getbettermaine.org, with implementation targeted for October 2015. Cost reporting has been a goal of the MHMC for a number of years now, so this endorsement represents a significant milestone in the Coalition’s public reporting efforts. The cost measure has also been endorsed by the SIM Steering Committee, along with a Resource Use Index score, but they deferred further decisions pending a review of a prototype website display.

E6e6d. Patient Provider Partnership Training for Primary Care Practices

The Patient-Provider Partnership (P3) Pilot provides quality improvement support to 10 practice sites across the state to promote more effective communication between patients and their health care providers and more active engagement of patients in their health care decisions. P3 Pilot sites focus on three priority areas which include the American Board of Internal Medicine Foundation’s Choosing Wisely health decision areas, Shared Decision Making involving lower back pain and Shared Decision Making involving medication in behavioral health. In year one P3 pilot sites participated in a P3 Learning Collaborative which included two daylong Learning Sessions focused on strategies for implementing Choosing Wisely or Shared Decision Making in their practices to better engage patients, monthly educational webinars that have built upon each other to guide the practices through the stages of implementation, a quarterly newsletter of information, and toolkits for each area of focus. Keeping busy clinical practices actively engaged is an ongoing challenge which the P3 Pilot has addressed by providing hands-on technical assistance from P3 Physician Consultants through site visits and conference calls to address practice-specific challenges to implementation.

As FY 2015 Q3, The Maine Quality Counts Patient-Provider Partnership (P3) Pilot supported by SIM completed its work in March 2015 and the best practices developed during the pilot continue to influence ongoing activity. During the Behavioral Health Homes Learning Session on June 25th, a P3 Pilot Organization, Tri-County Mental Health Services, shared the best practices learned from their work in implementing shared decision making for medication decisions in behavioral health, offering an opportunity for Behavioral Health Homes to explore implementing shared decision making as a way to engage and involve consumers in care planning.

E6e6d. Diabetes Prevention

The National Diabetes Prevention Program (NDPP), an evidence-based lifestyle change program focused on the prevention of Type 2 diabetes, has been proven to help people at high risk for type 2 diabetes prevent or significantly delay the disease by making modest lifestyle changes. [Maine CDC](#) and SIM grant partners are working with payers to test how this program can improve health outcomes and reduce healthcare costs when applied to Value Based Insurance Design (VBID), Patient Centered Medical Home (PCMH), and Accountable Care Organizations (ACO). If successful, this project will demonstrate the value of integrating NDPP into Maine's transformed healthcare system.

Section E. Part 7. Integration of Meaningful Use: “To-be,” “Gap Analysis,” and “Road Map”

The Meaningful Use Program and use of EHRs and HIT for individual and population health management is seen as essential for the success meeting our goal of achieving the IHI Triple Aim and Value Based Purchasing initiatives and programs.

In the below crosswalk we have aligned the highlevel programmatic goals of each of Maine’s DHHS stakeholder strategic plans and the SIM program strategy areas. Which includes goals the three following stakeholder strategic plans and incorporates them into the SIM strategic areas:

- Maine DHHS Strategic Goals
- MaineCare Strategic Goals
- Maine CDC State Health Improvement Plan Strategic Goals
-

It is clear that MaineCare’s goal of creating a data driven organization is vital to programmatic alignment on both the state and federal levels not only to provide a means of cost efficiency for both our state Medicaid program and beneficiaries but for means to provide data to show improved health outcomes which in return will provide better quality of care to our Medicaid beneficiaries and lead to increased access to care when our providers with the use of CEHRT and updated integrated Medicaid delivery systems are able to support Medicaid EPs and EHs in decision support to provide the correct quality of care, at the right place, at the right time. With this level of alignment we intend to spread this technology across all of our DHHS programs to share and promote better patient outcomes and adhere to the MITA Seven Conditions and Standards.

Maine DHHS, MaineCare, and Maine CDC Crosswalk			
DHHS Strategic Plan Goals	MaineCare Strategic Plan Goals	Maine CDC SHIP Priorities	SIM Strategic Pillars
Goal 1: Improve individual and public health	Goal 1: Improve individual and population health Goal 4: Create a data driven organization	Immunizations Obesity Substance Abuse and Mental Health Tobacco Use Inform, Educate and Empower the Public Mobilize Community Partnerships	Strengthen Primary Care Integrate Physical and Behavioral Health
Goal 2: Improve self-sufficiency of individuals and families	Goal 1: Improve individual and population health Goal 4: Create a data driven organization	Substance Abuse and Mental Health Tobacco Use Inform, Educate and Empower the Public Mobilize Community	Integrate Physical and Behavioral Health Develop New Workforce Models

		Partnerships	
Goal 3: Improve safety of individuals and communities	Goal 3: Foster a mission oriented, satisfied and effective workforce to achieve organizational excellence Goal 4: Create a data driven organization	Immunizations Obesity Substance Abuse and Mental Health Tobacco Use Inform, Educate and Empower the Public Mobilize Community Partnerships	Engage People and Communities Strengthen Primary Care Integrate Physical and Behavioral Health
Goal 4: Improve school-aged children’s ability to succeed	Goal 1: Improve individual and population health Goal 4: Create a data driven organization	Inform, Educate and Empower the Public Mobilize Community Partnerships	Engage People and Communities
Goal 5: Ensure efficient use of resources to achieve quality outcomes	Goal 2: Ensure efficient use of financial resources to achieve measurable health outcomes Goal 3: Foster a mission oriented, satisfied and effective workforce to achieve organizational excellence Goal 4: Create a data driven organization		Use Centralized Data & Analysis to Drive Change Support Development of New Payment Models
Goal 6: Increase access and quality for long-term care	Goal 1: Improve individual and population health Goal 4: Create a data driven organization		

Figure 96 - Maine DHHS, MaineCare, and Maine CDC Crosswalk

For the Health Homes, the use of EHRs to share information between the CCT and the practices was repeatedly mentioned by both CCTs and the Health Homes as an important factor in facilitating referrals and communication between CCT and practices regarding patient care.

CCTs that have worked with assigned practices both with and without access to the EHR indicated that access to the EHR allowed direct sharing of case notes and communication about the patient in a much timelier manner.

Some CCTs are working through practices with HealthInfoNet, Maine's Health Information Exchange, to receive real-time alerts about patients who had gone to the emergency room: In addition to referring patients who exhausted practice resources, many Health Homes are using data to determine which patients should get referred to the CCT, and which patients need and are not getting Health Home services. Several practices have developed in-house data reports that, for example, show patients by diagnosis that allow Health Home staff to identify gaps in care or areas where outreach may be needed.

Many examples of the benefits of EHRs and the MU Program are prevalent. Here is just one example: Staff might run a report on all Health Home patients who have asthma and cross check to see who has been in for a flu shot: One CCT worked with a Health Home patient who needed some simple fixes that a doctor or practice would never be able to pinpoint. On the CCT's first home visit, the patient's husband told the nurse that she never leaves her room. While talking to the patient, the CCT nurse noted she is on oxygen and asked where her oxygen was. The patient said she could only use it in her bedroom because she did not have a long enough cord to leave the room and stay connected to the oxygen. The CCT immediately got her a cord long enough so she could move around her house. CCT staff noted this is one example of something a practice would never see and may never ask about, but has a huge impact on the patients' emotional well-being.

“We are looking at the data more. So that means we are reaching out to more patients that haven't been in, that maybe are out of control... patients we didn't have a handle on before. We are tapping into resources more, and helping patients link up to these resources.”

“The biggest change to me is the amount of data: I don't think we've ever had so much (data) to interpret in my whole life! But that has created an increased awareness- you know, you always think you are doing a great job, but you look at your numbers and realize that you see you missed some people ... who needed flu shots or missed appointment.”

As stated above, the HIT Meaningful Use Program operates under the umbrella of broader programs and initiatives that use HIT extensively to meet program goals and standards. These ongoing and planned initiatives will be leveraged to coordinate activities and create a unified approach for the advancement of health information technology and exchange in Maine.

As example, the SIM grant operation plan includes references to the integration of communications and outreach efforts under the MaineCare Meaningful Use Program to better help inform the SIM grant and integrate HIT efforts in Maine. Maine's Health Homes initiative requires health care providers to use a certified EHR and to build capabilities to electronically exchange health care data. The State's Accountable Communities effort awards “points” to

Accountable Communities whose primary care professionals participate in the MaineCare or Medicare Meaningful Use Program.⁴⁷

Maine’s June 2011 SMHP outlined goals and objectives which represented the early phases of the MU Program. This SMHP modernizes those goals to reflect the improved technology gains over the past four years and which now looks forward to the emerging improved health outcomes under the Value-Based Purchasing umbrella which encompasses the State Innovation Model grant; accountable communities; and the health home programs. The updated goals (to-be), objectives (to-be), status and needs that flowed from the vision statements are summarized below:

“To-Be” Goals	
Goal 1.A. HIT Initiative Coordination Benefits	Recognizing the benefits of improved health outcomes and program cost efficiencies that a multi-dimensional approach to HIT may afford, MaineCare will realize increased efficiencies related to business processes and systems integrations that allow access to patients, caregivers, and clinical care coordinators and monitoring of patient care, through the coordination of Federal, State and DHHS-specific HIT initiatives and reporting mechanisms as defined by the MITA 3.0 Framework.
1.B. “To-Be” Key Objective	By 2019, all Federal, State and DHHS-specific HIT initiatives will be intrinsically linked through alignment and coordination of plans and clinical quality measures used to improve health outcomes for MaineCare beneficiaries, using data and technology standards as defined under the MITA 3.0 Framework to enable MaineCare to fully inform and provide the essential data needed to meet Triple Aim goals.
1.C. “As-Is”	The State will continue a governance structure that is collaborative, and with a public-private stakeholder advisory group to provide input and establish priorities and to identify and coordinate initiatives that have HIT components (such as the SIM grant, Health Homes, and Accountable Care, and among stakeholders including the Maine Health Data Organizations All Payer/All Claims database, HealthInfoNet, DHHS Offices, Maine Health Management Coalition Foundation, Maine Quality Counts, and other health care organizations and consumers).
1.D “Gap Analysis”	While Maine’s Meaningful Use Program has a great deal of integration with the State’s HIT systems and health care initiatives, the MU Program can be further integrated structurally and on an organization level to fully help inform the State’s Value Based Purchasing initiatives. Most stakeholders in Maine agree that meeting the Triple Aim will require the integration and sharing of both claims (administrative) and clinical data. This will require a public process to work through an effective governance process, structural models to collect and manage

⁴⁷ SIM, Health Homes and Accountable Community documents and overviews are available at: <http://www.maine.gov/dhhs/sim> or <http://www.maine.gov/dhhs/oms/vbp>.

	essential clinical data, and processes to analyze and report outcomes.
1.E “Road Map”	Continue to use collaborative processes and structures to ensure that HIT initiatives and activities are integrated as a part of healthcare transformation in the state, and are contributing to achieving the Triple Aim by informing healthcare systems on individual and population health questions and monitoring quality and clinical outcomes of healthcare initiatives
	Design, develop, and implement improvements to the State’s health information systems and exchange of health information to include CDC specialty registries and population health, with a key emphasis on reducing the burden on providers while providing critical quality, clinical and cost data to improve health outcomes;
	Continue and improve upon, coordination of all HIT initiatives between health care settings to avoid duplication of efforts and to allow federal and State resources and lessons learned to be used to improve health outcomes;
	Review existing quality measurement tools and reporting methods and provide mechanisms that disseminate and integrate Meaningful Use reports, including eQMs and population health measures, with emerging initiatives such as SIM, Health Homes and Accountable Communities;
	Efficiently use program funding to optimize the benefits of HIT by coordinating and aligning health and quality assurance measures with other programs.
	Support efforts of the State’s Maine Health Data Organization (MHDO), the State’s All Payer Claims Data-Base (APCD) to provide data at the PHI level while providing appropriate privacy and security.
	The State will review data elements submitted by EPs (and where applicable EHs) used to compile Maine’s annual report to CMS with a goal of making the annual report more readily available and more valuable as a quality tool for professionals, practices, payers, and programs. The expected result is a report that will include all of the data and elements of the CMS-developed annual report with Maine-specific elements added.

“To-Be” Goals	
Goal 2. Privacy and Security Benefits.	MaineCare will build public trust and enhance participation in HIT and electronic exchange of protected health information by incorporating privacy and security solutions and appropriate legislation, regulations, and processes in every phase of its development, adoption and use.
“To-Be” Goal 2. Key Objective	By 2019, MaineCare will facilitate electronic exchange, access, and use of electronic protected health information, while maintaining the privacy and security of patient, provider and clearinghouse health information through the advancement of privacy and security legislation, policies, principles, procedures and protections for protected

	health information that is created, maintained, received or transmitted.
“As-Is” Goal 2	A Legal Work Group (LWG) that was convened to inventory existing privacy and security standards and practices including HIPAA and other Federal and State-specific laws culminated in a February 2013 law which builds on Maine’s opt-out for general health and opt-in for mental health care data for inclusion into the State-wide HIE.
“Gap Analysis” Goal 2	Although many patients have data in the HIE, there are gaps remaining: Mental health care data is flowing into the HIE yet naturally at a much slower rate given that it is “opt-in.” Substance abuse information (Part 2) is not currently available in the HIE.
“Road Map” Goal 2.	The State will continue to work with stakeholders to perform a feasibility study of how to integrate Part 2 data in the exchange of health information.
	Continued outreach and education will be performed to demonstrate to patients and providers the benefits of HIT and the appropriate exchange of data.
	Additional legislation, as needed, will be introduced to further the privacy and security of data.
	The Department, through its Director of Privacy and Security, will continue and will improve the implementation and continued adherence to HIPAA and other privacy and security laws, through its regularly scheduled privacy meetings and updates to security laws.

“To-Be” Goals	
Goal 3. Communication, Education and Outreach Benefits	MaineCare will aid in transforming the current health care delivery system into a high performing health information exchange system by establishing and implementing robust communication, education, and outreach plans to promote wide-spread EHR , Meaningful Use, and exchange among MaineCare providers and inform Members about the benefits of health information technology.
“To-Be” Goal 3. Key Objective	Continuing its work through 2019, MaineCare will have highly promoted the national and State HIT efforts to improve health outcomes through the use of electronic health information tools by developing and implementing comprehensive communication and training programs for State decision makers, staff, providers, citizens of Maine and stakeholders, and the promotion of exchange and sharing PHI where appropriate, to make informed health care decisions.
“As-Is” Goal 3.	State’s Meaningful Use Program conducted extensive communication strategies that assisted providers in understanding the HITECH Act, Meaningful Use requirements, and the benefits of HIT for the providers as well as the patients. The methods employed included reference and links to the CMS HIT websites; in-person provider forums; webinars; conference calls; participation in provider organization events; written literature; and one-on-one discussions and site visits. Groups involved with the communication included the State’s REC, Maine Quality Forum, Primary Care Association, Hospital and Provider Associations,

	<p>consumer groups, Maine’s APCD, Maine’s State-wide HIE, and the like.</p> <p>In 2013, in cooperation with the State’s Broadband Agency, MaineCare conducted a Medicaid provider survey to update and build upon the late 2010 baseline assessment of EHR use among providers. The survey results are being used to conduct outreach and education on the goals, objectives, and benefits of EHR and Meaningful Use initiatives, and how to leverage other sources of funding available for HIT efforts.</p>
“Gap Analysis” Goal 3.	<p>The State will continue outreach and training programs for DHHS decision makers, MaineCare management and State staff so that they may educate providers and Members about the benefits of HIT and provide Member education on HIT to empower them to effectively make decisions about their health information in an informed manner.</p>
“Road Map” Goal 3.	<p>In 2013, in cooperation with the State’s Broadband Agency, MaineCare conducted a Medicaid provider survey to update and build upon the late 2010 baseline assessment of EHR use among providers. The survey results are being used to conduct outreach and education on the goals, objectives, and benefits of EHR and Meaningful Use initiatives, and how to leverage other sources of funding available for HIT efforts.</p> <p>Maine needs to continue its collaborative efforts among State agencies and stakeholder organizations to further promote the use of tele-health which is greatly needed given Maine’s rural nature and the aging populations. To fully take advantage of tele-health and other emerging technologies, Maine must continue its efforts to provide a communications/broadband structure that provides access to high-speed internet services that are capable of providing home monitoring and the provision of mental and physical health services, needed for “aging in place” goals.</p>

“To-Be” Goals	
Goal 4. Infrastructure, Systems Benefits	<p>The MaineCare MU program will advance the provision of services that are client-centered to improve health outcomes, quality, patient safety, engagement, care coordination, and efficiency of the health care system and reduce operating costs by eliminating duplication of data costs through promoting adoption and Meaningful Use of health information technology, and adherence to the CMS MITA Framework.</p>
“To-Be” Goal 4. Key Objective	<p>By 2019, all MaineCare Members will be managed by DHHS and providers who have secure access to health related information within a connected health care system using data and technology standards that enable movement of electronic health information to support patient and population-oriented health care needs and which meet Meaningful Use requirements.</p>

<p>“As-Is” Goal 4.</p>	<p>The State greatly improved the capability of health information exchange under its OSC cooperative agreement and its partnership with the ONC. Maine developed and implemented enhancements where needed, to the State’s registration, attestation and payment systems for Eligible Professionals and Hospitals (if Medicaid only) to report Meaningful Use Stage 1 and 2 quality measures.</p>
<p>“Gap Analysis” Goal 4.</p>	<p>Maine has made efforts to remove data silos among State systems to collect and manage data to better serve citizens. The removal of data silos is also critical to health care providers who are frequently called upon to report large amounts of health care data to various offices and programs, resulting in duplication of efforts and resources. The MU Program should continue to focus on programs across Maine with an eye toward efficiency gains such as reducing entries into multiple systems and implementing streamline reporting.</p> <p>Decision makers and stakeholders agree that a coordinated effort for the reporting of clinical quality measure across programs will improve population health efforts. Work on this effort should continue.</p> <p>Currently, there is one state-wide HIE in Maine. All agree that the HIE has served Maine well over the past five years and the HIE continues to grow and prosper throughout the state, providing valuable services and products. However, the HIE operates under a customer-based voluntary frameworks. Providers sign agreements to participate in the HIE. Some providers and stakeholders have shared that there may be up to significant barriers for participation. For example, providers must pay to participate in the exchange, and while there is a sliding-scale payment mechanism, cost can be a barrier.</p> <p>Participants must be connected to the HIE which involves having interoperable system capabilities and it can take between three to nine months to get a connection, depending on the provider’s vendor and system.</p> <p>Providers must have a certified E H R which many EPs and EHs have, but long term care and behavioral health practices do not because they are not eligible for incentive payments and typically lag behind in HIT initiatives.</p> <p>Broadband may not be accessible for some smaller or rural practices. Barriers, whether with HIT technology or the exchange of data must be brought down to have a truly integrated and accessible exchange of health information. The barriers inherently, do not lend themselves to creating a level-playing field where all providers and patients, and important decision-making points have an integrated one-person, one-record repository of their claims (administrative) and clinical data. The Department should look toward policies that promote a “level playing field” for all.</p>

<p>“Road Map” Goal 4.</p>	<p>Building on the work of the Legal Work Group and stakeholder process, the State should continue processes that result in a “level playing field” where all providers and citizens and decision points have access to claims and clinical data without obstacles or ownership issues at the individual patient level.</p> <p>The Department should determine the feasibility of internal or partnership-based databases and system(s) that can “slice and dice” the data submitted by providers under the several initiatives (SIM, Health Homes, Accountable Communities, the MU Program, CDC Specialty Registries, IHOC, etc.) and disseminate it to the various programs in the format required by the program. Thus, the Department or a partnership-based system would allow providers to submit data from Meaningful Use, system reports, etc. which would be fed to a central repository where the data would be converted to the format and elements of the various required reports. (e.g., HEDES, NCQA, etc.)</p>
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Section E. Part 8. Conclusion

Since the submission of the 2011 SMHP, Maine has reached many of its’ initial goals and continues to position itself for successful future implementations of the Medicaid HIT vision and Incentive Payment Program as they relate to the overall Medicaid Enterprise Architecture and the MITA framework, but there is still much work to be done. Maine continues to appreciate the partnership and collaboration it shares with its federal partners, CMS and the Office of the National Coordinator. Maine intends to build and expand upon the state’s external and internal stakeholder relationships to achieve all joint state and federal goals and efforts that are available through federal funding. Maine will continue to promote electronic health records and the integration of Medicaid delivery systems to provide better health outcomes, more cost-efficient health care, with an emphasis on member management and patient engagement for our beneficiaries. To-date Maine has achieved many positive results that have been facilitated by health information technology and the many funding opportunities that have been made available by our federal partners to enable closer integration, collaboration and economies of scale for Maine’s Information Technology, telehealth, broadband, and related initiatives. We look forward to these continued partnerships as we progress toward the advancement of our Medicaid Enterprise Architecture for our current and future planning and development efforts.

SMHP LIST OF APPENDICIES

- APPENDIX A-1** – SMHP Template CMS Crosswalk
- APPENDIX A-2**- EHR Incentive Program – Administration and Oversight Areas – Definitions and Requirements
- APPENDIX A-3**- HIE Related Service Definitions
- APPENDIX A-4** - MITA Visions, Goals and Objectives
- APPENDIX A-5** – MITA Business Area High-Level Findings
- APPENDIX B-1** – CMS Guidance –“To Be” Landscape
- APPENDIX C-1** – CMS SMHP Template Crosswalk
- APPENDIX C-2** – Description of Process Flows
- APPENDIX C-3** – Register EP or EH Sub-Process
- APPENDIX C-4** – Determine Eligibility
- APPENDIX C-5** – Switch EP between Program and/or State
Sub-Process
- APPENDIX C-6** – Submit Payment Request and Attestations
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Certified EHR Technology Attestations Sub-Activity
- APPENDIX C-8** - MU Attestation
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- APPENDIX C-10** – Adjudicate Payment
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- APPENDIX C-12** – Appeals Sub-Process
- APPENDIX C-13** – Annual CMS Report
- APPENDIX C-14** – Submit Quarterly HHS Report Sub-Process
- APPENDIX C-15** – Managing Provider Inquiries and Deliver Provider
Education
- APPENDIX C-16** – Deliver Provider Communications
- APPENDIX C-17** – Develop Rules
- APPENDIX C-18** – Maintain SMHP
- APPENDIX C-19** – Revise HIT Landscape
- APPENDIX C-20** – Revise Roadmap

APPENDIX C-21 – Submit IAPD Sub-Process

APPENDIX C-22 – Track and Report FFP

APPENDIX C-23 – Manage FFP for Providers

APPENDIX D-1 – CMS SMHP Template Crosswalk

APPENDIX E-1 – CMS SMHP Template Crosswalk

SMHP Template CMS Crosswalk

Question Number	CMS Guidance	“As-Is” Landscape Section
1.	What is the current extent of EHR adoption by practitioners and by hospitals? How recent is this data? Does it provide specificity about the types of EHRs in use by the State’s providers? Is it specific to just Medicaid or an assessment of overall statewide use of EHRs? Does the SMA have data or estimates on eligible providers broken out by types of providers? Does the SMA have data on EHR adoption by types of provider (e.g. children’s hospitals, acute care hospitals, pediatricians, nurse practitioners, etc.)?	Section A2c
2.	To what extent does broadband internet access pose a challenge to HIT/E in the State’s rural areas? Did the State receive any broadband grants?	Section A2b
3.	Does the State have Federally Qualified Health Center networks that have received or are receiving HIT/EHR funding from the Health Resources Services Administration (HRSA)? Please describe.	Section A2c(3), A4d
4.	Does the State have Veterans Administration or Indian Health Service clinical facilities that are operating EHRs? Please describe.	Section A2c(4), A4d(2), A4d(4)
5.	What stakeholders are engaged in any existing HIT/E activities and how would the extent of their involvement be characterized?	Sections A and B.
6.	Does the SMA have HIT/E relationships with other entities? If so, what is the nature (governance, fiscal, geographic scope, etc) of these activities? <i>CMS indicated that this question may be deferred.</i>	Section A, parts 1 Section E6a
7.	Specifically, if there are health information exchange organizations in the State, what is their governance structure and is the SMA involved? How extensive is their geographic reach and scope of participation? <i>CMS indicated that the first part of this question may be deferred but States do need to include a description of their HIE geographic reach and current level of participation.</i>	Section A4c, A4c(1)
8.	Please describe the role of the MMIS in the SMA’s current HIT/E environment. Has the State coordinated their HIT Plan with their MITA transition plans and if so, briefly describe how.	Section A4b(1)

Question Number	CMS Guidance	“As-Is” Landscape Section
9.	What State activities are currently underway or in the planning phase to facilitate HIE and EHR adoption? What role does the SMA play? Who else is currently involved? For example, how are the regional extension centers (RECs) assisting Medicaid eligible providers to implement EHR systems and achieve Meaningful Use?	Section A Part 4 Section B Part 1 Section E Part 6
10.	Explain the SMA’s relationship to the State HIT Coordinator and how the activities planned under the ONC-funded HIE cooperative agreement and the Regional Extension Centers (and Local Extension Centers, if applicable) would help support the administration of the EHR Incentive Program.	Section A4c
11.	What other activities does the SMA currently have underway that will likely influence the direction of the EHR Incentive Program over the next five years?	Section A, Part 4 Section E Part 6
12.	Have there been any recent changes (of a significant degree) to State laws or regulations that might affect the implementation of the EHR Incentive Program? Please describe.	Section A Part 3, A4c5
13.	Are there any HIT/E activities that cross State borders? Is there significant crossing of State lines for accessing health care services by Medicaid beneficiaries? Please describe.	Section A4c1
14.	What is the current interoperability status of the State Immunization registry and the Public Health Surveillance reporting database(s)?	Section A, Part C4
15.	If the State was awarded an HIT-related grant, such as a Transformation Grant or a CHIPRA HIT grant, please include a brief description.	Section A4b2b

**EHR INCENTIVE PROGRAM – ADMINISTRATION AND OVERSIGHT AREAS
DEFINITIONS AND REQUIREMENTS**

EHR Incentive Program administration and oversight areas	Definition and Requirements
Appeals Process	The process should allow for a provider to appeal based on the criteria in the Final Rule regarding eligibility, Meaningful Use, and payment.
Audit Process	The process should verify incentive payments, provider eligibility determinations, and the demonstration of efforts to adopt, implement, or upgrade EHR technology, and Meaningful Use eligibility related to the EHR Incentive Payment Program.
Payment Process	The process should ensure that there is no duplication of Medicare and Medicaid incentive payments to EPs. The process must also ensure that EHR incentive payments are made for no more than 6 years. Additionally the process should verify that all hospital calculations and incentives are paid correctly.
Program Registration	The process should allow EPs and eligible hospitals to sign up for the Medicaid EHR Incentive Program and verify that the EP or EH has not registered for the Medicaid EHR Incentive Program in any other state.
Provider Communications	The process should facilitate communication between EPs and EHs and the Medicaid agency.
Provider Questions	The process should facilitate the receipt and timely response to questions from EPs and EHs.
Reporting Requirements	The process should fulfill all reporting needs as required by CMS and the State.
Tracking Attestations	The process should verify that all provider information including eligibility, NPI, TIN, Meaningful Use, and efforts to adopt, implement, or upgrade are all true and accurate.
Tracking Expenditures	The process should verify that no amounts higher than 100 percent of FFP will be claimed for reimbursement of expenditures for State payments to Medicaid EPs for the EHR Incentive Payment Program, and that no amounts higher than 90 percent of FFP will be claimed for administrative expenses in administering the certified EHR Incentive Payment Program.
Verifying Eligibility	The process should ensure that each Eligible Professional (EP) and Eligible Hospital (EH) meets all provider enrollment eligibility criteria upon enrollment and re-enrollment to the Medicaid EHR incentive payment program. These criteria include meeting the patient volume threshold and being a non-hospital based EP.

HIE RELATED SERVICE DEFINITIONS

HIE –Related Service	Definition
Advance Directives Management	Maintains and exchanges a patient’s legal documentation such as a living will, durable power of attorney for health care, etc.
Audit Trail	Tracks when, where, and what data was accessed and who accessed the data through an HIE entity
Care Coordination	Mechanisms that enable clinical summary exchange (e.g. referrals/discharges, disease management) across provider settings for individual patients
Clinical Decision Support	Distributes standardized clinical rules that can be incorporated into EHR systems or e-Prescribing systems in support of clinical decision making at the point of care
Clinical Portal	A web-based service offered to providers for accessing, viewing, and downloading clinical data available from data sources connected to an HIE
Community Resource Management	A mechanism for facilitating real time resource utilization and availability
Consultations / Transfers of Care	The mechanism(s) enabling information flows between requesting and consulting clinicians, often used during transfers of care occurring when a patient is discharged and transferred from one health setting to another
Consumer Empowerment/Access	A mechanism enabling consumers access to their health information through a personal health record or patient portal
Cross-Enterprise User Authentication	A mechanism for identifying and authenticating clinical system users to validate their right to access clinical information based upon privacy rules, patient consent, and individual user and organizational roles
Diagnostic Results Reporting	A mechanism for facilitating the delivery of patient diagnostic results (e.g., radiology and pathology reports) for use in clinical care
Eligibility & Claims Exchange	A mechanism to allow providers to electronically check patient eligibility status, submit and process claims transactions, and view claims history
Integration Engine (Data Transformation)	A mechanism for facilitating the intake of data in multiple formats in real time through the use of an integration engine, which transforms the data into a useable format
Laboratory Results	A mechanism for facilitating the delivery of patient lab results for use in clinical care
Medication Management	A mechanism for maintaining and exchanging medication history, medication formularies, and prescription information (e.g. ePrescribing)

HIE –Related Service	Definition
Patient Consent Management	A process for defining levels of patient consent and for tracking those consents and authorizations to share personal health information through an HIE entity
Patient Identifier	A methodology and related services used to uniquely identify an individual person as distinct from other individuals and connect his or her clinical information across multiple providers using an Enterprise Master Patient Index (EMPI)
PHI De-identification	A mechanism for removing demographic and other person-identifying data from personal health information and other health care data so that they can be used for public health reporting, quality improvement, research, benchmarking, and other secondary uses
Provider	A set of services that enhance a provider’s ability to deliver care, move between delivery settings, and comply with regulatory requirements (e.g., regulatory reporting, secure provider messaging, credentialing)
Public Health	A set of services that fulfill various state and Federal public health and chronic disease management practice requirements – such as biosurveillance, predictive modeling, health risk assessment, and case management – by leveraging and aggregating data available through an HIE entity
Quality Reporting	Process and mechanism to measure, aggregate, and report on hospital and clinician quality and use of quality measures to support clinical decision-making, accountability, and transparency
Record Locator	A mechanism for identifying and matching multiple patient records together from different data sources
Research	A mechanism that provides authorized individuals the ability to query either a centralized repository or multiple data sources to produce a de-identified report for an approved research project
Terminology Service	A service that ties together technology, nomenclature, data-element, or coding-transactions standards across disparate systems, normalizing (among others) HIPAA-standard transaction sets including HL7 and ANSI, LOINC, SNOMED CT, RxNorm, IDC, NCPDP, HCPCS, CPT, and document terminology

Footnote:22

MITA Vision, Goals, and Objectives	Alignment with HIT
Design and implement new systems	
Improve quality and efficiency of Health Care Delivery	✓
Improve member and population health	✓
Environment- flexibility, adaptability, rapid response to program/technology changes	
Enterprise view- technologies aligned with Medicaid business processes/technologies	
Coordinate with public health and other partners to integrate health outcomes	✓
Establish systems that are interoperable with common standards	✓
Timely, accurate, usable, and accessible data	✓
Use of performance measures	✓
Adopt data and industry standards	✓
Promote reusable components	
Efficient and effective data sharing	✓
Provide member focus	✓
Support interoperability, integration, and open architecture	✓
Promote good practices (e.g. Capability Maturity Model)	
Business-driven enterprise architecture	
Commonalities and differences co-exist	
Standards first	

Footnote:24

Table summarizing the MITA Business Assessment including the MITA Business Area, the capability maturity model level, and high level findings:

MITA Business Area	Level	High-level findings
Member Management	2	Applications are initiated via a paper process Data Hub exchanges eligibility data from disparate systems and MIHMS MIHMS maintains comprehensive member information for multiple programs
Provider Management	3	Provider enrollment is consistent across Medicaid enterprise National Provider ID and other HIPAA data standards are used Verifications of licenses, certifications, etc. are performed on-line
Contractor Management	2	AdvantageME is used to manage and store vendor information AdvantageME provides self-service (payment status) to vendors DHHS Allocation database contains RFP and contract data
Operations Management	2	Claims processing functionality is rule-based and highly automated QNXT functionality creates capitation payments, premium assistance payments, and Electronic Funds Transferred (EFT) transactions based on established parameters HIPAA standard transactions are used throughout operational processes
Program Management	3	Comprehensive suite of tools supports efficient and effective management and monitoring of financial transactions (FFP, accounts receivable & payable) Development and maintenance of benefit packages is facilitated by table driven structure Pre-defined and customizable reports address management needs
Care Management	2	Manual and automated processes are used to establish and monitor compliance Candidates are determined based on needs and received services
Program Integrity Management	2	State-of-the art utilization review system monitors providers and members MITA data and interface standards are used

MITA Business Area	Level	High-level findings
Business Relationship Management	3	Standard agreements are used to establish the relationship Business rules are consistently maintained and enforced Security is maintained in conformance with HIPAA

SMHP Template CMS Crosswalk

Question Number	CMS Guidance	“To-Be” Landscape Report Section
1.	Looking forward to the next five years, what specific HIT/E goals and objectives does the SMA expect to achieve? Be as specific as possible; e.g., the percentage of eligible providers adopting and meaningfully using certified EHR technology, the extent of access to HIE, etc.	Section B Parts 1 and 2
2.	What will the SMA’s IT system architecture (potentially including the MMIS) look like in five years to support achieving the SMA’s long-term goals and objectives? Internet portals? Enterprise Service Bus? Master Patient Index? Record Locator Service?	Section B, Parts 1 and 2
3.	How will Medicaid providers interface with the SMA IT system as it relates to the EHR Incentive Program (registration, reporting of MU data, etc.)?	Section B, Parts 1 and 2 Section C
4.	Given what is known about HIE governance structures currently in place, what should be in place by 5 years from now in order to achieve the SMA’s HIT/E goals and objectives? While CMS does not expect the SMA to know the specific organizations will be involved, etc., CMS would appreciate a discussion of this in the context of what is missing today that would need to be in place five years from now to ensure EHR adoption and meaningful use of EHR technologies.	Section B, Parts 1 and 2
5.	What specific steps is the SMA planning to take in the next 12 months to encourage provider adoption of certified EHR technology?	Section B, Parts 1 and 2
6.	** If the State has FQHCs with HRSA HIT/EHR funding, how will those resources and experiences be leveraged by the SMA to encourage EHR adoption?	Section B1c
7.	How will the SMA assess and/or provide technical assistance to Medicaid providers around adoption and meaningful use of certified EHR technology?	Section B2c Section C
8.	** How will the SMA assure that populations with unique needs, such as children, are appropriately addressed by the EHR Incentive Program?	Section B2e
9.	If the State included in a description of a HIT-related grant award (or awards) in Section A, to the extent known, how will that grant, or grants, be leveraged for implementing the EHR Incentive Program, e.g. actual grant products, knowledge/lessons learned, stakeholder relationships, governance structures, legal/consent policies and agreements, etc.?	Section B1c – B1e

Question Number	CMS Guidance	“To-Be” Landscape Report Section
10.	Does the SMA anticipate the need for new or State legislation or changes to existing State laws in order to implement the EHR Incentive Program and/or facilitate a successful EHR Incentive Program (e.g. State laws that may restrict the exchange of certain kinds of health information)? Please describe.	Section B2b

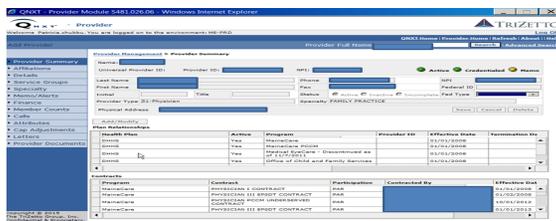
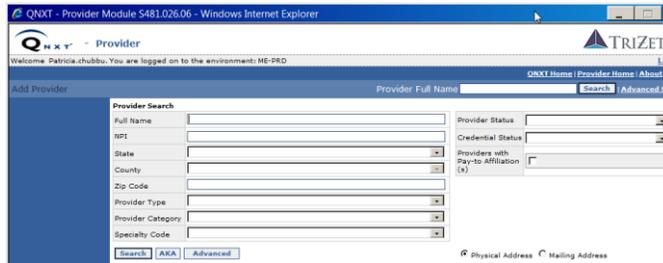
SMHP Template CMS Crosswalk

Question Number	CMS Guidance	EHR Incentive Program Process Report Section
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1. How will the SMA verify that providers are not sanctioned, are properly licensed/qualified providers?

Section C, Parts 1 and 2

1. Active status in MIMS is checked for each provider



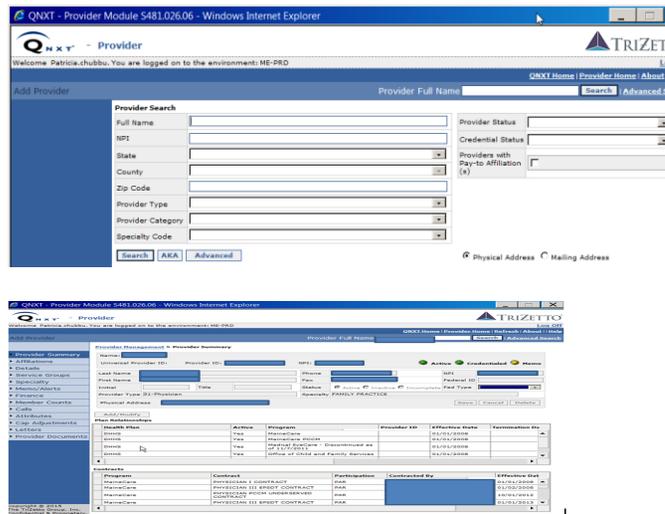
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Question Number	CMS Guidance	EHR Incentive Program Process Report Section
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1. How will the SMA verify that providers are not sanctioned, are properly licensed/qualified providers?

Section C, Parts 1 and 2

1. Active status in MIMS is checked for each provider



2. Verification of license status in the State of Maine at Maine Regulatory Licensing &

Permitting site:
Maine SMHP December 2015

<http://pfr.informe.org/almsonline/almquery/SearchIndividual.aspx?AspxAutoDetectCookieSupport=1>

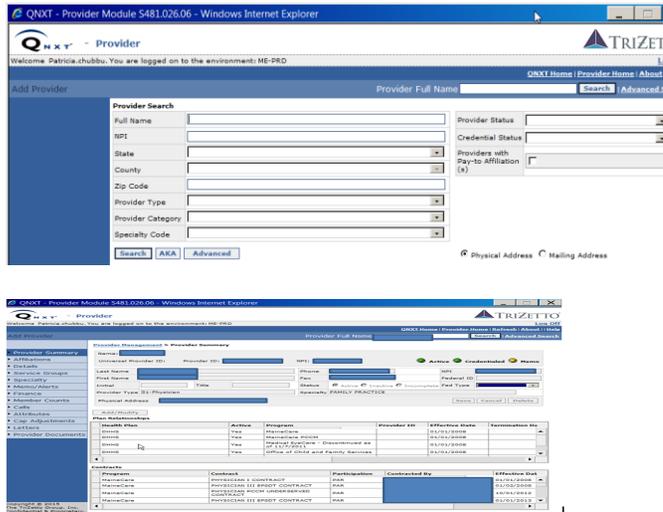
SMHP Template CMS Crosswalk

Question Number	CMS Guidance	EHR Incentive Program Process Report Section
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1. How will the SMA verify that providers are not sanctioned, are properly licensed/qualified providers?

Section C, Parts 1 and 2

1. Active status in MIMS is checked for each provider



2. How will the SMA verify whether EPs are hospital-based or not?

• Section C, Parts 1 and 2

1. Requested on the Medicaid Eligibility worksheet:

- Provider selects from a drop down list of the following:

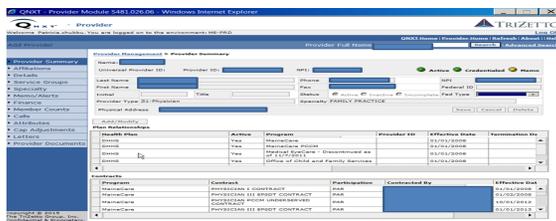
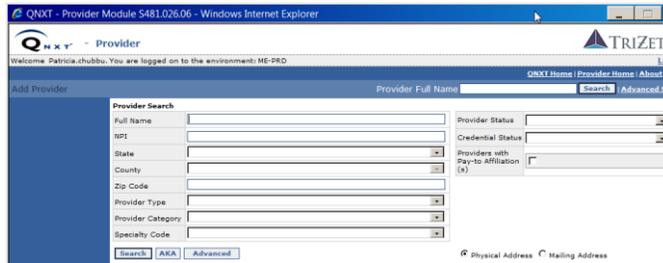
SMHP Template CMS Crosswalk

Question Number	CMS Guidance	EHR Incentive Program Process Report Section
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1. How will the SMA verify that providers are not sanctioned, are properly licensed/qualified providers?

Section C, Parts 1 and 2

1. Active status in MIMS is checked for each provider



3. How will the SMA verify the overall content of the provider attestations?

• Section C, Parts 1 and 2

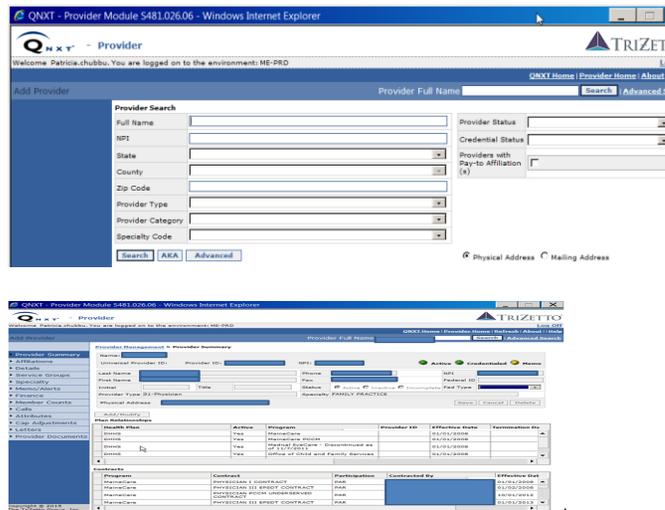
SMHP Template CMS Crosswalk

Question Number	CMS Guidance	EHR Incentive Program Process Report Section
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1. How will the SMA verify that providers are not sanctioned, are properly licensed/qualified providers?

Section C, Parts 1 and 2

1. Active status in MIMS is checked for each provider



4. How will the SMA communicate to its providers regarding their eligibility, payments, etc.?

• Section C, Parts 1 and 2

1. Provider registers on NLR for first participation year:
 - a. Email: SMA SLR sends instructions for the first participation year and an

Maine SMHP December 2015 attached Medicaid Eligibility worksheet to the provider

2. Provider contacts SMA to begin a new program year:
 - a. Email: SMA SLR sends instructions for the next participation year and an attached Medicaid Eligibility worksheet to the provider. Provider submits completed Medicaid Eligibility worksheet to SMA SLR.

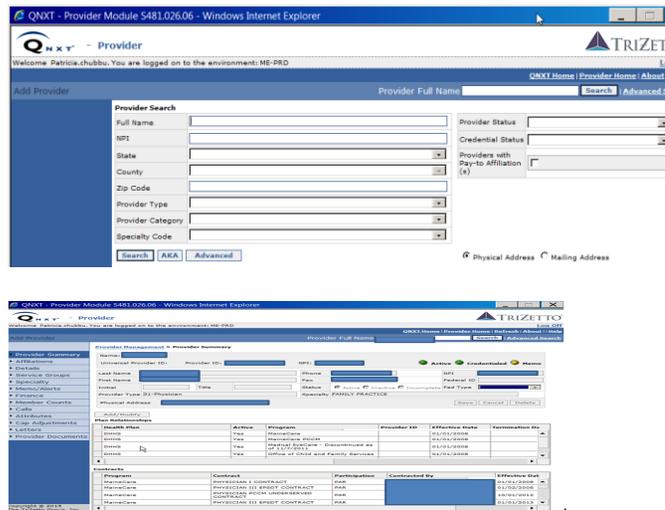
SMHP Template CMS Crosswalk

Question Number	CMS Guidance	EHR Incentive Program Process Report Section
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1. How will the SMA verify that providers are not sanctioned, are properly licensed/qualified providers?

Section C, Parts 1 and 2

1. Active status in MIMS is checked for each provider



5. What methodology will the SMA use to calculate patient volume?

• Section C, Parts 1 and 2

1. MaineCare will apply the State encounter methodology to calculate patient volume

thresholds. Maine recognizes and will apply the different threshold requirements based on the type of EP. For example, for an EP to be eligible as an FQHC EP, the EP must practice predominantly in the FQHC and must meet a 30% needy individual patient threshold. Non-FQHCs, (other than pediatricians) must be non-hospital based (90% or less of their practice is done outside the hospital settings as described in the process flow

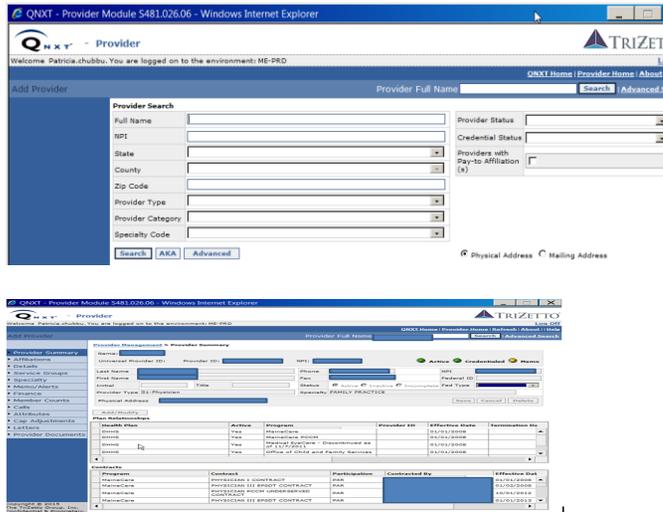
SMHP Template CMS Crosswalk

Question Number	CMS Guidance	EHR Incentive Program Process Report Section
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1. How will the SMA verify that providers are not sanctioned, are properly licensed/qualified providers?

Section C, Parts 1 and 2

1. Active status in MIMS is checked for each provider



6. What data sources will the SMA use to verify patient volume for EPs and acute care hospitals?
 1. Hospitals- Medicare cost report
 2. Providers – MIMMS

• Section C, Parts 1 and 2

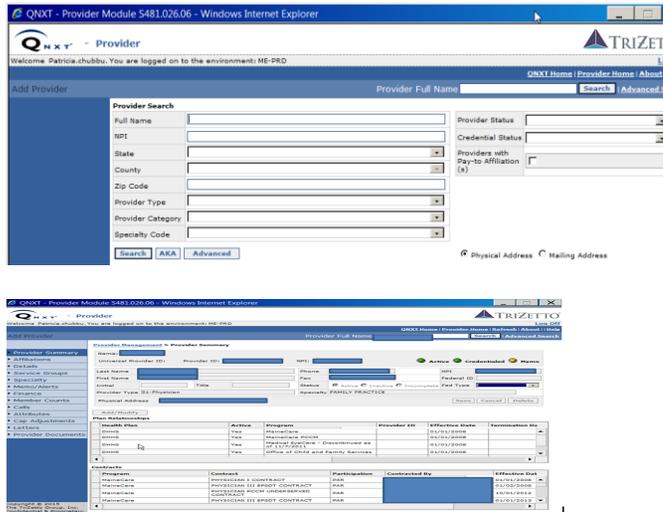
SMHP Template CMS Crosswalk

Question Number CMS Guidance EHR Incentive Program Process Report Section

1. How will the SMA verify that providers are not sanctioned, are properly licensed/qualified providers?

Section C, Parts 1 and 2

1. Active status in MIMS is checked for each provider



7. How will the SMA verify that EPs at FQHC/RHC meet the practices predominantly requirement?

• Section C, Parts 1 and 2

1. Requested on the Medicaid Eligibility worksheet. Provider selects from a drop down

Maine SMHP December 2015 choice of:

- Not applicable
- Provider works at an FQHC/RHC and meets the practices predominately definition

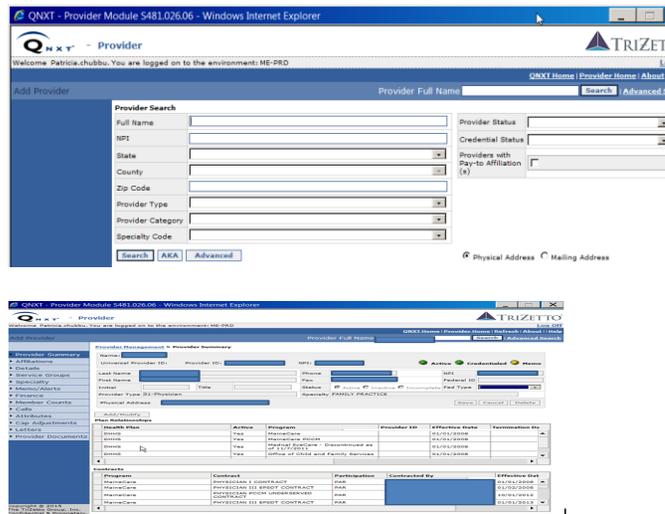
SMHP Template CMS Crosswalk

Question Number	CMS Guidance	EHR Incentive Program Process Report Section
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1. How will the SMA verify that providers are not sanctioned, are properly licensed/qualified providers?

Section C, Parts 1 and 2

1. Active status in MIMS is checked for each provider



8. How will the SMA verify adopt, implement or upgrade of certified electronic health record technology by providers?

• Section C, Parts 1 and 2

- CEHRT information requested on the Medicaid Eligibility worksheet; submitted information is then verified on the CHPL site and a copy of the CHPL verification is saved in providers file at SMA.

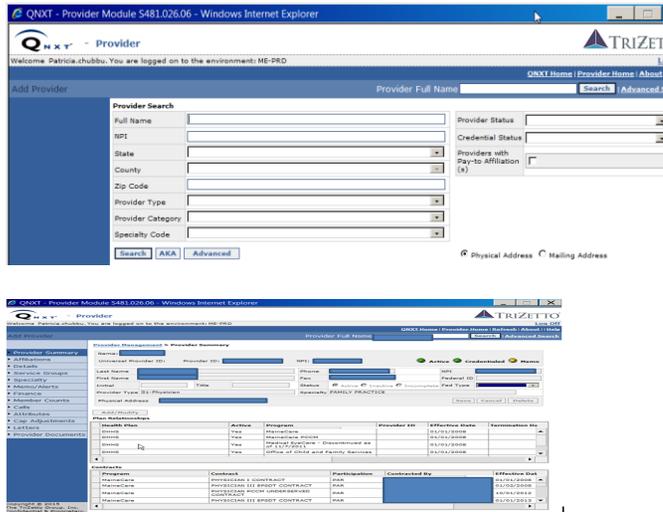
SMHP Template CMS Crosswalk

Question Number	CMS Guidance	EHR Incentive Program Process Report Section
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1. How will the SMA verify that providers are not sanctioned, are properly licensed/qualified providers?

Section C, Parts 1 and 2

1. Active status in MIMS is checked for each provider



9. How will the SMA verify meaningful use of certified electronic health record technology for providers' second participation year?

• Section C, Parts 1 and 2

2. CEHRT information requested on the Medicaid Eligibility worksheet for each program year; submitted information is then verified on the CHPL site and a copy of the CHPL

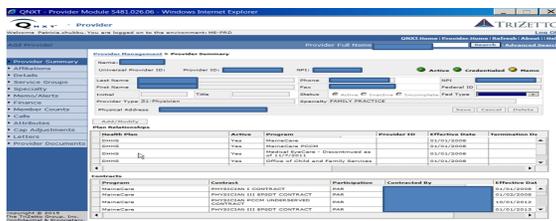
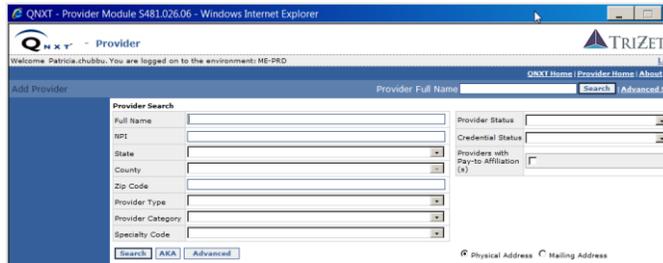
SMHP Template CMS Crosswalk

Question Number CMS Guidance EHR Incentive Program Process Report Section

1. How will the SMA verify that providers are not sanctioned, are properly licensed/qualified providers?

Section C, Parts 1 and 2

1. Active status in MIMS is checked for each provider



10. Will the SMA be proposing any changes to the Meaningful Use definition as permissible per the final rule? If so, please provide details on the expected benefit to the Medicaid population as well as how the SMA assessed the issue of additional provider reporting and financial burden.

• Maine is not proposing changes to the

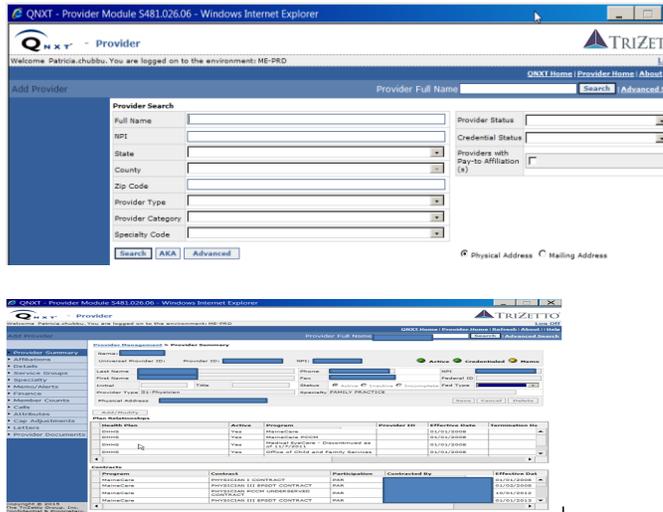
SMHP Template CMS Crosswalk

Question Number	CMS Guidance	EHR Incentive Program Process Report Section
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1. How will the SMA verify that providers are not sanctioned, are properly licensed/qualified providers?

Section C, Parts 1 and 2

1. Active status in MIMS is checked for each provider



11. How will the SMA verify providers' use of certified electronic health record technology?

• Section C, Parts 1 and 2

1. Audit Procedure for verification of CEHRT - see Audit Strategy Section D

2. CEHRT information supplied by the provider on the Medicaid Eligibility worksheet; submitted information is then verified on the CHPL site and a copy of the CHPL verification is saved in providers file at SMA

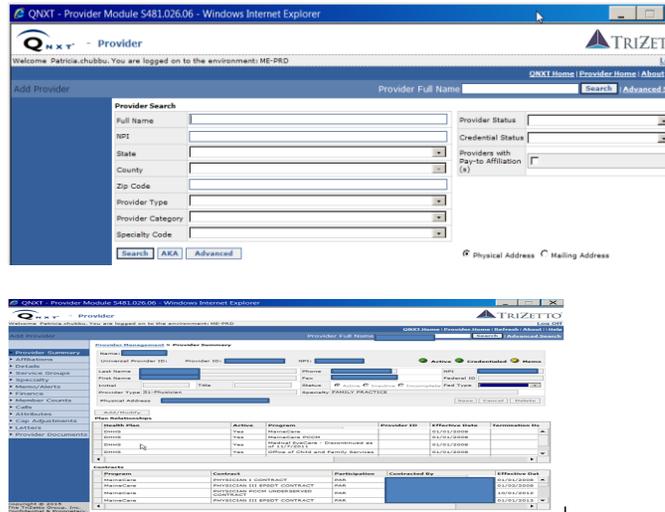
SMHP Template CMS Crosswalk

Question Number	CMS Guidance	EHR Incentive Program Process Report Section
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1. How will the SMA verify that providers are not sanctioned, are properly licensed/qualified providers?

Section C, Parts 1 and 2

1. Active status in MIMS is checked for each provider



12. How will the SMA verify providers’ meaningful use data, including the reporting of clinical quality measures? Does the State envision different approaches for short-term and a different approach for the longer-term?

• Section C, Parts 1 and 2

1. Provider inputs the meaningful use data derived from their CEHRT MU reports into the SMA developed “wizard” application. The data is sent from within the application directly into the SLR for review by the SMA.

2. The manual input of MU data into the wizard application is our proposed approach for both short term and long term

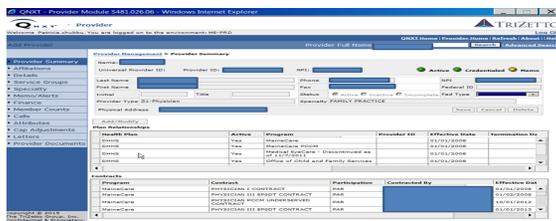
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1. How will the SMA verify that providers are not sanctioned, are properly licensed/qualified providers?

Section C, Parts 1 and 2

1. Active status in MIMS is checked for each provider



13. *How will data collection and analysis process align with the collection of other clinical quality measures data, such as CHIPRA?

• Section A, Part 6; Section C, Parts 1 and 2

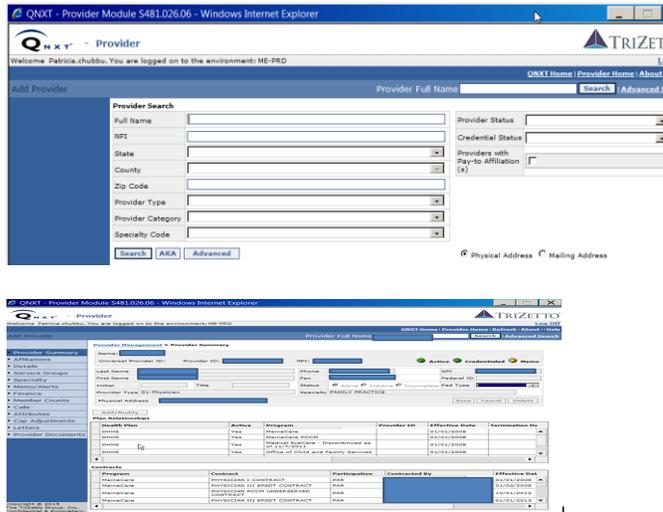
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1. How will the SMA verify that providers are not sanctioned, are properly licensed/qualified providers?

Section C, Parts 1 and 2

1. Active status in MIMS is checked for each provider



14. What IT, fiscal and communication systems will be used to implement the EHR Incentive Program?

• All Sections

1. IT: Maine has developed a home grown SLR that has exceeded our expectations for the EHR Incentive program. We have the ability to quickly update and implement re-design as needed.
2. Fiscal: Maine's finance division tracks the grant allocation and disbursement.
3. Communication Systems:
 - a. Maine EHR incentive program help desk email system provides for direct

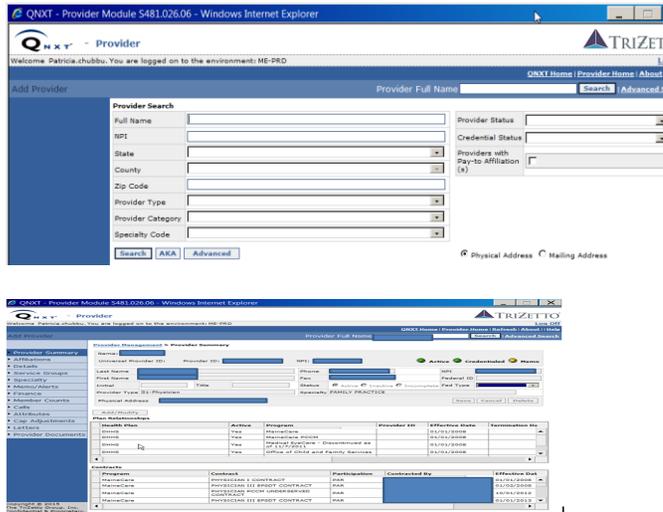
SMHP Template CMS Crosswalk

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1. How will the SMA verify that providers are not sanctioned, are properly licensed/qualified providers?

Section C, Parts 1 and 2

1. Active status in MIMS is checked for each provider



15. What IT systems changes are needed by the SMA to implement the EHR Incentive Program?

• See Section E- Part 7

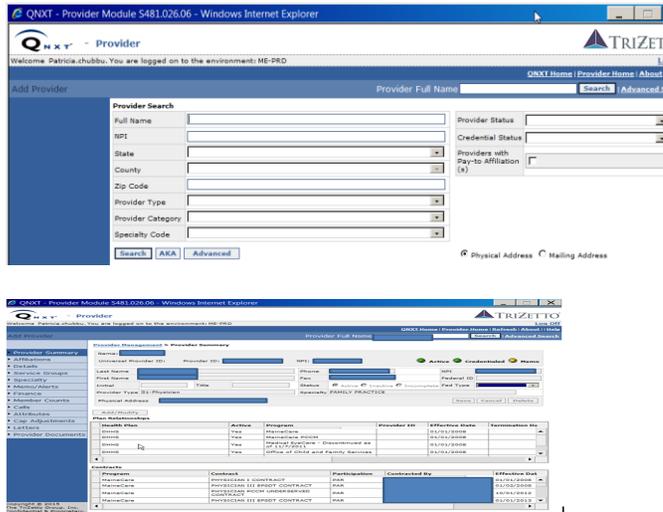
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1. How will the SMA verify that providers are not sanctioned, are properly licensed/qualified providers?

Section C, Parts 1 and 2

1. Active status in MIMS is checked for each provider



16. What is the SMA's IT timeframe for systems modifications?

• See Section E- Part 7

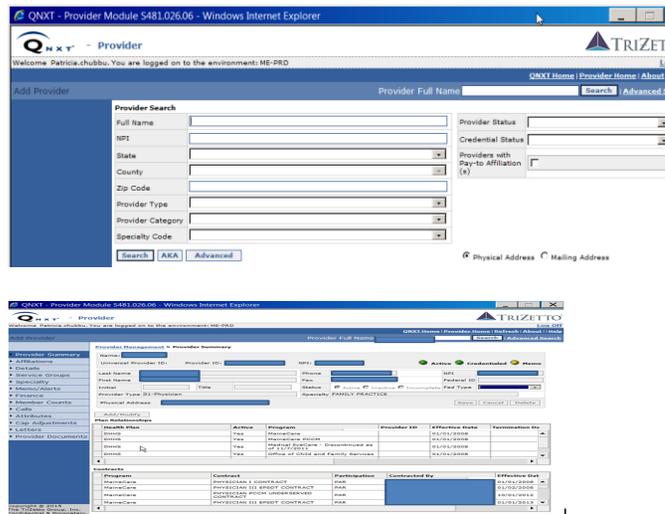
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1. How will the SMA verify that providers are not sanctioned, are properly licensed/qualified providers?

Section C, Parts 1 and 2

1. Active status in MIMS is checked for each provider



17. When does the SMA anticipate being ready to test and interface with the CMS National Level Repository (NLR)?

• See Section E- Part 7

The SMA began accepting attestations on the following dates:
Maine SMHP December 2015

AIU applications on October 3, 2011

Stage 1 applications in program year 2012

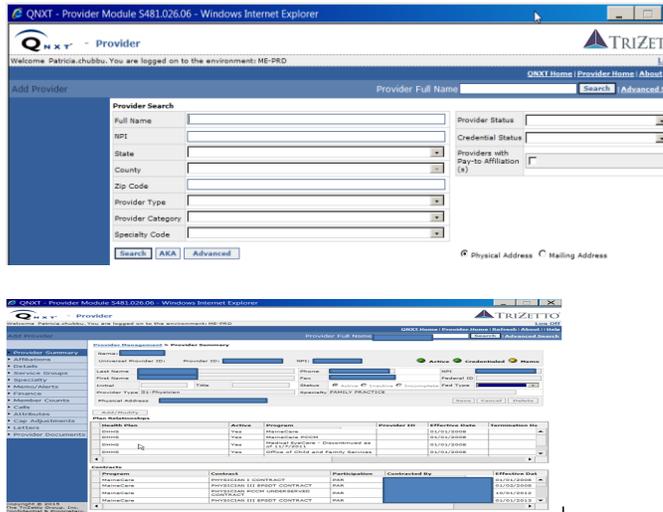
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1. How will the SMA verify that providers are not sanctioned, are properly licensed/qualified providers?

Section C, Parts 1 and 2

1. Active status in MIMS is checked for each provider



18. What is the SMA’s plan for accepting the registration data for its Medicaid providers from the CMS NLR (e.g. mainframe to mainframe interface or other means)?

• Section C, Parts 1 and 2

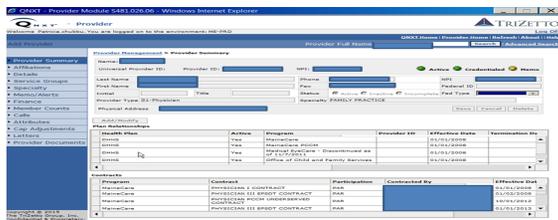
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1. How will the SMA verify that providers are not sanctioned, are properly licensed/qualified providers?

Section C, Parts 1 and 2

1. Active status in MIMS is checked for each provider



19. What kind of website will the SMA host for Medicaid providers for enrollment, program information, etc.?

• Section C, Parts 1, 2 and 5

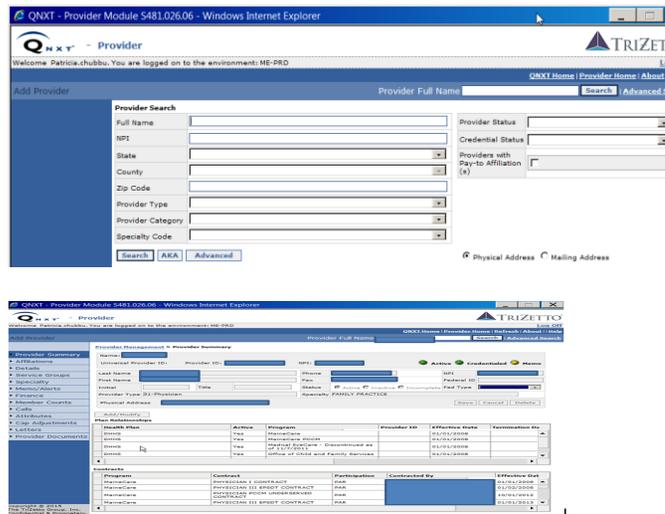
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Section C, Parts 1 and 2

1. Active status in MIMS is checked for each provider



20. Does the SMA anticipate modifications to the MMIS and if so, when does the SMA anticipate submitting an MMIS IAPD?

- See Section E- Part 7

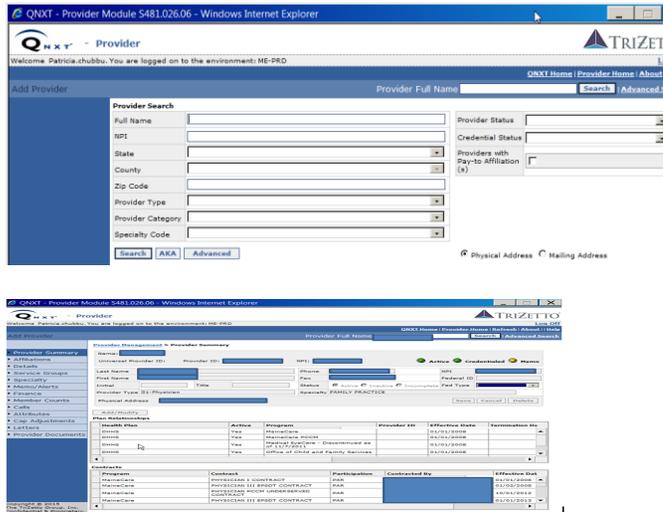
SMHP Template CMS Crosswalk

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1. How will the SMA verify that providers are not sanctioned, are properly licensed/qualified providers?

Section C, Parts 1 and 2

1. Active status in MIMS is checked for each provider



21. What kinds of call centers/help desks and other means will be established to address EP and hospital questions regarding the incentive program?

• Section C, Parts 1 and 2

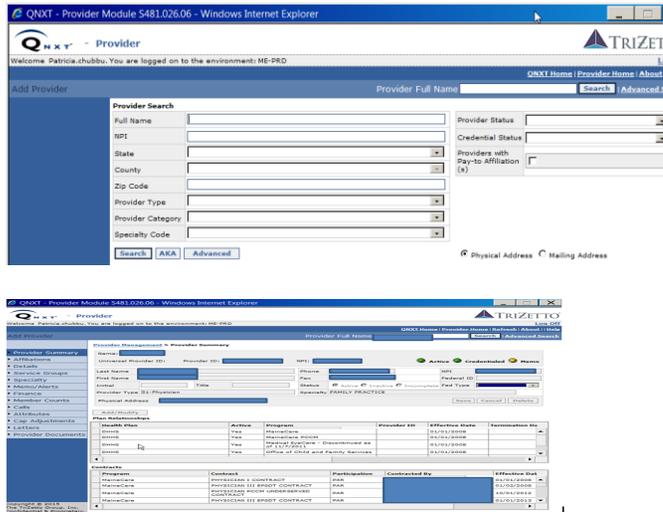
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1. How will the SMA verify that providers are not sanctioned, are properly licensed/qualified providers?

Section C, Parts 1 and 2

1. Active status in MIMS is checked for each provider



22. What will the SMA establish as a provider appeal process relative to: 1) the incentive payments, 2) provider eligibility determinations, 3) demonstration of efforts to adopt, implement or upgrade and meaningful use of certified EHR technology?

Section C, Part 3

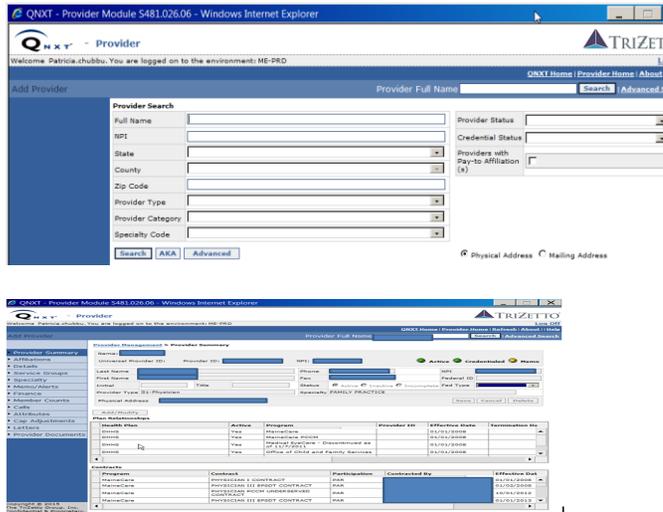
SMHP Template CMS Crosswalk

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1. How will the SMA verify that providers are not sanctioned, are properly licensed/qualified providers?

Section C, Parts 1 and 2

1. Active status in MIMS is checked for each provider



23. What will be the process to assure that all Federal funding, both for the 100 percent incentive payments, as well as the 90 percent HIT administrative match, are accounted for separately for the HITECH provisions and not reported in a commingled manner with the enhanced MMIS

• Sections C, Part 6

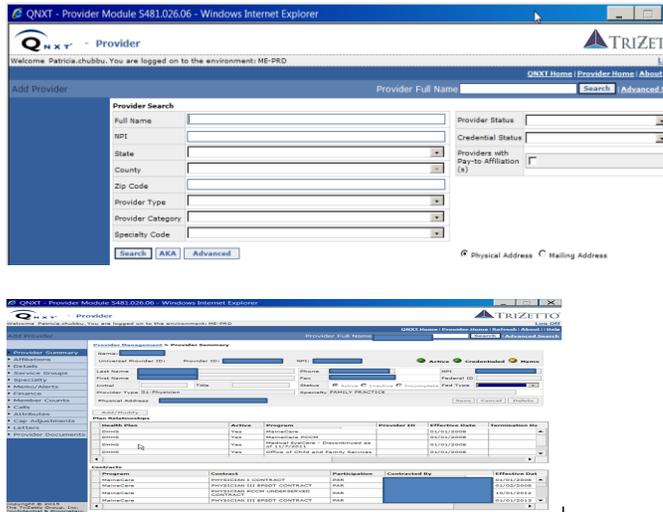
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1. How will the SMA verify that providers are not sanctioned, are properly licensed/qualified providers?

Section C, Parts 1 and 2

1. Active status in MIMS is checked for each provider



24. What is the SMA’s anticipated frequency for making the EHR Incentive Payments (e.g. monthly, semi-monthly, etc.)?

• Section C, Part 2

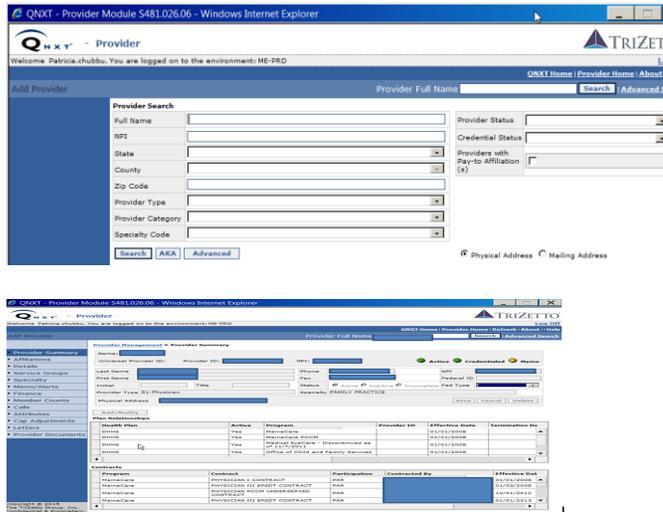
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1. How will the SMA verify that providers are not sanctioned, are properly licensed/qualified providers?

Section C, Parts 1 and 2

1. Active status in MIMS is checked for each provider



25. What will be the process to assure that Medicaid provider payments are paid directly to the provider (or an employer or facility to which the provider has assigned payments) without any deduction or rebate?

• Section C, Part 2

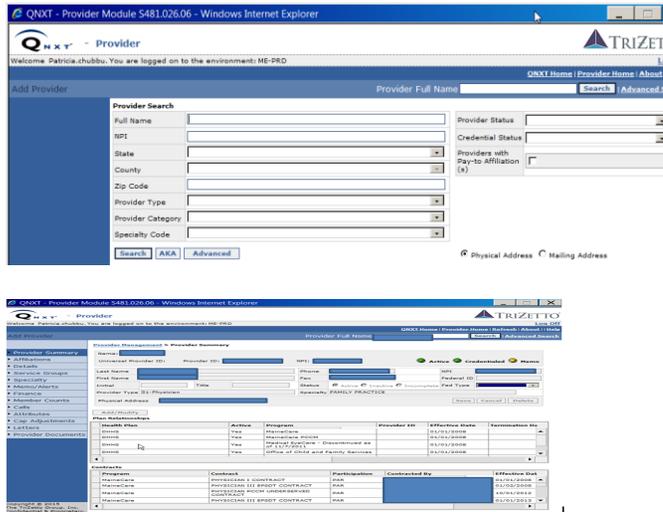
SMHP Template CMS Crosswalk

Question Number	CMS Guidance	EHR Incentive Program Process Report Section
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1. How will the SMA verify that providers are not sanctioned, are properly licensed/qualified providers?

Section C, Parts 1 and 2

1. Active status in MIMS is checked for each provider



26. What will be the process to assure that Medicaid payments go to an entity promoting the adoption of certified EHR technology, as designated by the state and approved by the US DHHS Secretary, are made only if participation in such payment arrangement is voluntary by the EP and that no more than 5 percent of such payments is retained for costs unrelated to EHR technology adoption?

• Section C, Part 2

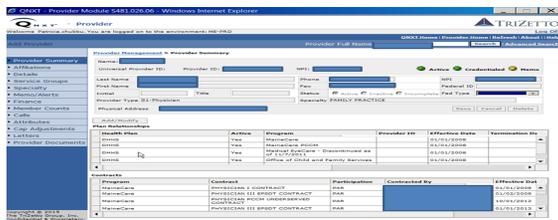
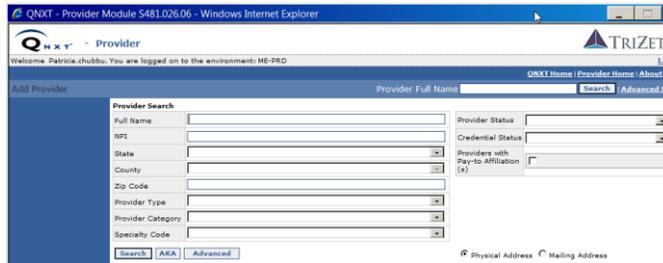
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1. How will the SMA verify that providers are not sanctioned, are properly licensed/qualified providers?

Section C, Parts 1 and 2

1. Active status in MIMS is checked for each provider



27. What will be the process to assure that there are fiscal arrangements with providers to disburse incentive payments through Medicaid managed care plans does not exceed 105 percent of the capitation rate per 42 CFR Part 438.6, as well as a methodology for verifying such information?

• Section C, Part 2

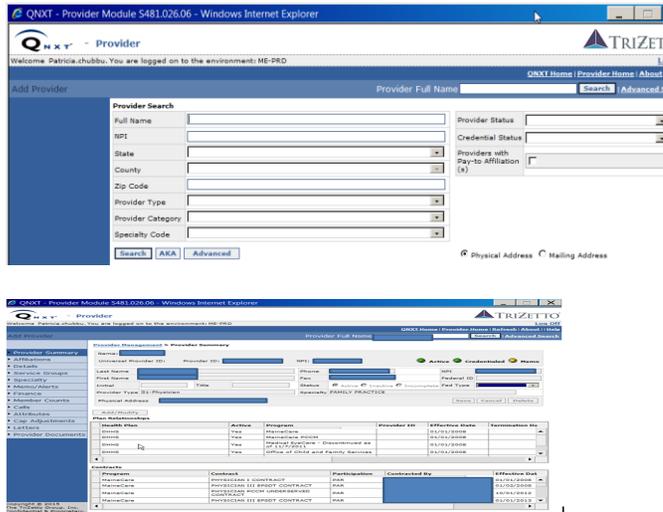
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Section C, Parts 1 and 2

1. Active status in MIMS is checked for each provider



28. What will be the process to assure that all EH calculations and EP incentive payments (including tracking EPs' 15% of the net average allowable costs of certified EHR technology) are made consistent with the Statute and regulation?

• This question is no longer relevant per the

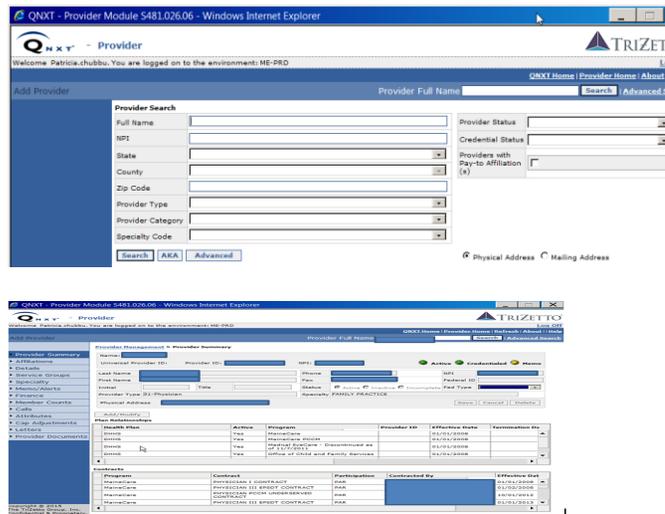
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Section C, Parts 1 and 2

1. Active status in MIMS is checked for each provider



29. What will be the role of existing SMA contractors in implementing the EHR Incentive Program- such as MMIS, PBM, fiscal agent, managed care contractors, etc.?

• See Section E- Part 7

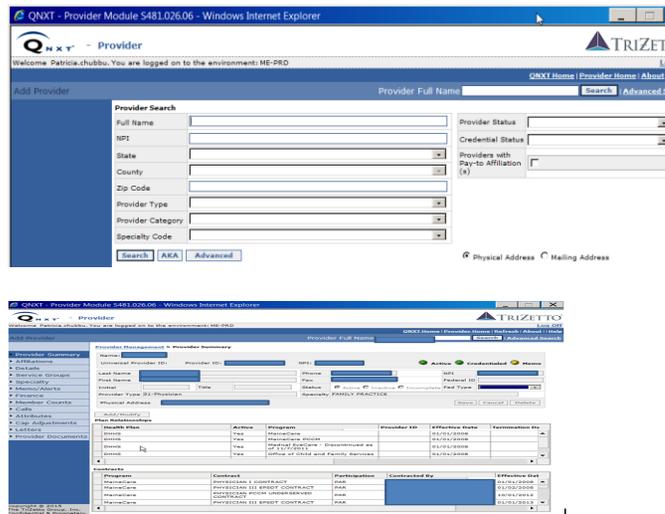
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Section C, Parts 1 and 2

1. Active status in MIMS is checked for each provider



30. States should explicitly describe what their assumptions are, and where the path and timing of their plans have dependencies based upon:

- Throughout the SMHP

- The status/availability of certified EHR technology

Description of Processes for Activities Taken to Administer the EHR Incentives Program

In the previous 2011 SMHP workflows were provided to identify the actions taken within the program to achieve the federal requirement. In the 2015 version Maine will provide screenshots taken from the SLR to supply this information. Appendices C-2 through C-23 should be used in conjunction to the screen shots listed in Section C of the SMHP to provide a detailed description of the business processes and activities taken to administer MaineCare’s Medicaid EHR Incentive Program.

The left column on the sub-process graph identifies the “who” (CMS, OMS, Provider) that is taking or receiving the activity (action):

Entity Who is Taking or Receiving the Action	Description
Eligible Professionals (EP) and Eligible Hospitals (EH)	<p>An Eligible Professional (EP) in the Medicaid EHR Incentive Program is defined as a physician, a dentist, a certified nurse-midwife, a nurse practitioner, or a physician assistant who is practicing in a Federally Qualified Health Center (FQHC) led by a physician assistant, or a Rural Health Clinic (RHC) led by a physician assistant. EPs must meet the 30% (at least 20% if pediatrician) Medicaid patient volume requirements and cannot be hospital-based professionals as defined in the Final Rule as providing substantially all (more than 90%) of their clinical activity in an inpatient or emergency room setting. For FQHC EPs to be eligible, they must meet the 30% “needy individual” requirements.</p> <p>Eligible hospitals (EH) for the Medicaid EHR Incentive Program include Acute Care and Children’s Hospitals. To be eligible for a Medicaid EHR incentive payment, Acute Care Hospitals must have at least a 10% patient volume attributable to Medicaid (Title XIX). Children’s Hospitals do not have patient volume requirements under Medicaid. Hospitals are eligible to receive both Medicare and Medicaid EHR Incentive payments in the same year.</p>
CMS	Centers for Medicare & Medicaid Services (CMS) is the US Federal agency which administers Medicare, Medicaid, and the Children's Health Insurance Program. CMS directly oversees and conducts the Medicare Incentive Payment Programs. CMS oversees state Medicaid Agency HIT and EHR Incentive Payment Programs. CMS will also maintain the National Level Repository (NLR), the system that will facilitate and capture EP and Hospital registration for the Medicare and Medicaid EHR Incentive Programs.

Office of MaineCare Services	The Office of MaineCare Services (OMS) is the entity responsible for administering and overseeing the Maine Medicaid HIT Program, including the EHR Incentive Payment Program.
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Process: Register EP or EH Sub-Process

Tasks in this process:

RE-010-010: Register for EHR Incentive Program

Description:	<p>Description: EPs and EHs will login to the NLR to register for the EHR Incentive Program. They will navigate to the Home tab and login by entering their User ID and Password. From there, they will complete the registration form. The registration form will capture information such as demographics, TIN, CCN and other identifying information.</p> <p>Once the form is completed, the EP or EH will complete a legal notice attesting that the information they provided is complete and accurate to the best of their knowledge. The form will then be submitted to the NLR for processing.</p> <p>Resources: EP/EH, CMS</p> <p>Proposed Technology to leverage: NLR</p>
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RE-010-020: Confirm Medicare/Medicaid Enrollment Status and Check for Exclusions

Description:	<p>Description: Upon receiving the registration request from the EP or EH, the NLR will complete an initial check of the EP/EH Medicare/Medicaid enrollment status and a check for exclusions.</p> <p>Resources: CMS</p> <p>Proposed Technology to leverage: NLR</p>
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RE-010-030: Populate NLR

RE-010-040: Search for Duplicate Registration

Description:	<p>Description: The NLR will run a check for any duplicate registrations the EP or EH may have made for Medicare or Medicaid in a different state.</p> <p>Resources: CMS</p> <p>Proposed Technology to leverage: NLR</p>
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RE-010-050: Add Registration Record

Description:	<p>Description: If duplicate registration check is cleared, a registration record</p>
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	<p>is created for the EP or EH.</p> <p>Resources: CMS</p> <p>Proposed Technology to leverage: NLR</p>
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RE-010-060: Send Status to EP/EH

Description:	<p>Description: Once a registration record is created for the EP or EH, the registration status is posted to the Inquiry tab of the NLR.</p> <p>Resources: CMS</p> <p>Proposed Technology to leverage: NLR</p>
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RE-010-070: Receive CMS Registration Status

Description:	<p>Description: To receive notice of registration status, the EP or EH will log into the NLR and navigate to the Inquiry tab. The registration information and status for the EP or EH will be updated and posted to the Inquiry tab.</p> <p>Resources: EPs or EHs</p> <p>Proposed Technology to leverage: NLR</p>
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RE-010-080: Send Registration Information to State

Description:	<p>Description: Parallel with posting the EPs or EHs registration status to the Inquiry tab of the NLR, the NLR will send MaineCare the EP's or EH's registration information, which will include the provider's TIN, CCN, demographic information, and program selection.</p> <p>Resources: CMS</p> <p>Proposed Technology to leverage: NLR</p>
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RE-010-090: Receive Registration Information from CMS

Description:	<p>Description: MaineCare receives the EP's or EH's registration information. The information comes into the SLR via a B6 transaction from the NLR.</p> <p>Resources: CMS, MaineCare Services</p>
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	Proposed Technology to leverage: Maine OIT developed system
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RE-010-100: Queue Registration Request

Description:	<p>Description: The registration request is then queued and routed to the OMS HIT Team.</p> <p>A B6 notification email comes into the Maine HIT program email system with the following information:</p> <ol style="list-style-type: none"> 1. Action of B6 –registration added, updated, inactivated, in progress 2. Provider registration number 3. Provider name and State <p>Resources: MaineCare Services</p> <p>Proposed Technology to leverage: Maine OIT developed system</p>
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RE-010-110: Review and Verify Provider Registration Information

Description:	<p>Description: With a successful NLR registration the provider receives an automated email from the SLR (see test version below) with instructions and an attached Medicaid Eligibility worksheet. The provider completes the eligibility worksheet with provider and payee information, the application option (AIU or MU) with specifications for what MU definition year and stage, CEHRT information and the Medicaid eligibility calculation. The provider submits the completed worksheet to MaineCare via email. The HIT Specialist will assist the provider with the application process. MaineCare will review and verify the registration information by cross-checking against provider enrollment information within appropriate data sources for active/pending sanctions, licensing, and the eligibility requirements for the EHR Incentive Program as documented in the Final Rule.</p> <p>Resources: MaineCare Services</p> <p>Proposed Technology to leverage: Maine OIT developed system MIHMS Online Provider Enrollment Portal</p>
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Process: Determine Eligibility**Tasks in this process:**

RE-020-000: Register with Registry to meet Public Health Objective and Measure

Description:	<p>Description: EPs must register their intent to initiate ongoing submission for a given Public Health Objective, before or within 60 days of the start of their EHR Reporting Period. This registration may be done prior to or after the provider’s eligibility for the program has been determined, using the Maine CDC “Register Practice Wizard,” a downloadable application that collects practice and provider data necessary for onboarding for Maine’s immunization, electronic lab reporting, syndromic surveillance and cancer registries. Only one registration is needed if the EP is choosing to achieve multiple Public Health Objectives. Registration data is maintained in a common repository and is used by the registries and the EHR Incentive Program to manage onboarding and program compliance.</p> <p>The registration is submitted by practice site and must include each submitting provider at the site. A registration confirmation is sent to the practice contact e-mail that documents the date and time of submission for each EP. If a practice needs to add additional providers to the original registration, the Wizard retains the practice data and may be reused. The date of registration for added providers will be the date of the original practice registration.</p> <p>Modified 2015-2017 Stage 2 Public Health Reporting Active Engagement definition and options:</p> <ul style="list-style-type: none"> • <i>Definition:</i> Active Engagement means that a provider is in the process of moving towards sending “production data” (data generated through actual clinical process involving patient care) to a PHA or CDR. • <i>Active Engagement Option 1 - Completed Registration to Submit Data:</i> The EP, EH or CAH registered to submit data with the PHA or, where applicable, the CDR to which the information is being submitted; registration was completed within 60 days after the start of the EHR reporting period; and the EP, EH, or CAH is awaiting an invitation from the PHA or CDR to begin testing and validation. • <i>Active Engagement Option 2 - Testing and Validation:</i> The EP, EH, or CAH is in the process of testing and validation of the electronic submission of data. Providers must respond to
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	<p>requests from the PHA or, where applicable, the CDR, within 30 days; failure to respond twice within an EHR reporting period would result in that provider not meeting the measure.</p> <ul style="list-style-type: none"> • <i>Active Engagement Option 3</i> - The EP, EH, or CAH has completed testing and validation of the electronic submission and is electronically submitting production data to the PHA or CDR. <p>Resources: MaineCare Services</p> <p>Proposed Technology to leverage: Maine OIT developed system and Public Health Registry</p>
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RE-020-010: Apply Eligibility Methodology

Description:	<p>Description: MaineCare will apply the encounter method to calculate patient volume thresholds and ensure that all eligibility criteria as defined in the Final Rule (including "practices predominantly", "hospital based", and that hospitals have demonstrated an average length of stay of 25 days or less) are met. MaineCare will check that providers are not sanctioned and are licensed.</p> <p>Encounter: An encounter is defined as any service rendered to an individual on any one day by any one provider. This means that if a patient sees two providers in the same practice on the same day, the practice may consider this 2 separate encounters when determining patient volume.</p> <p>Medicaid Encounter: A Medicaid encounter is defined as any service rendered on any one day by any one provider to a Medicaid eligible member. This means that if a Medicaid patient sees two providers in the same practice on the same day, the practice may consider this 2 separate Medicaid encounters when determining patient volume.</p> <p>Patient volume thresholds have been and will continue to be calculated based on “total Medicaid or total needy individual patient encounters in any representative continuous 90-day period in the 12 months preceding the EP or eligible hospital's attestation or based upon a representative, continuous 90-day period in the calendar year preceding the payment year for which the EP or eligible hospital is attesting.” (CMS Final Rule § 495.306B(2)ii Establishing patient volume). Some providers may opt to use 3 months of data versus a 90 day period while there are occasions that a calculation could be based on 91 or 92 when the 3 months have greater</p>
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than 30 days in any month used.

For Program Years 2011 and 2012, CHIP stand-alone and expansion encounters must be excluded from the eligible encounter calculation. For program years 2013 and beyond, CHIP encounters to be included into the patient volume calculation will be expanded to include patients in Title 19 and Title 21 Medicaid expansion programs. Stand-alone encounters will still be excluded from the eligible encounter calculation.

The State uses a proxy method based on the calendar year number of in-state CHIP claims by each county in Maine. The state wide calculation is the average of all county totals. If a provider is found to be not eligible using the state wide CHIP percentage the State will allow the provider to use the county level CHIP percent; if the county level causes the provider to not meet eligibility the State will allow the individual's providers CHIP numbers. The State includes this flexibility because CHIP encounters are not identifiable by the provider/ambulatory office setting. The State then subtracts the resulting percentage from the percentage of eligible encounters to make a preliminary determination of whether the EP or Eligible Hospital (EH) meets the percentage of Medicaid encounters required for Program participation. The proxy percentage applied for Program Year 2011 is 2.28%; the proxy percentage applied for Program Year 2012 is 2.21%.

Beginning with Program Year 2013, CHIP stand-alone encounters must be excluded from the eligible encounter calculation. The proxy percentage applied for Program Year 2013 is .75%. The proxy percentage applied for Program Year 2014 is .66%. The proxy percentage applied for Program Year 2015 is .74%. The State will submit an updated proxy amount for subsequent Program Years as they are determined.

Because the State is using an average calculation and it is based on claims, any EP or EH who is preliminarily found to be ineligible for the Meaningful Use Program due to not meeting the Medicaid encounter threshold, will be notified and offered the opportunity to provide specific numbers of actual CHIP encounters and total encounters to determine whether the EP or EH meets the threshold of MaineCare encounters needed for Program participation.

For the purpose of calculating FQHC "Needy Patient" volume for Program Years (2011 – 2014) MaineCare under 495.306 (g) had established an alternative methodology for calculating this volume due to the lack of information regarding billing and payment of these encounter

	<p>types. MaineCare has used the HRSA UDS Table 4 – Socioeconomic Characteristics that is required for submission to receive Bureau of Primary Health Care grant funding. The information is reported for a full year compliant to reporting requirements for this program. MaineCare then determined the patient volume calculation by dividing the total “Needy Population” number by the number of 90 day reporting periods (4) required for participation in the EHRIP program within the year. This is consistent with all rules governing the SMHP at §495.332. For Program Years 2015 and beyond MaineCare will be removing this alternative methodology and calculating “Needy Patient” volume as proposed by CMS.</p> <p>Resources: MaineCare Services</p> <p>Proposed Technology to leverage: Maine OIT developed system</p>
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RE-020-020: Determine/Set Eligibility Status

<p>Description:</p>	<p>Description: Once the registration request is reviewed and the eligibility methodology is applied, the EP's or EH's registration record is updated to reflect the determined eligibility status.</p> <p>Resources: MaineCare Services</p> <p>Proposed Technology to leverage: Maine OIT developed system</p>
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RE-020-030: Send Eligibility Status

<p>Description:</p>	<p>Description: MaineCare will send the status of the EP or EH to CMS via the NLR interface. If the EP or EH was determined ineligible, the reason code will be included. MaineCare will send the eligibility status to the EP or EH.</p> <p>Resources: MaineCare Services</p> <p>Proposed Technology to leverage: NLR, Maine OIT developed system</p>
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RE-020-040: Receive Eligibility Status

<p>Description:</p>	<p>Description: CMS receives the eligibility status from the State via the NLR interface.</p> <p>Resources: CMS</p>
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	Proposed Technology to leverage: NLR, Maine OIT developed system
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RE-020-050: Send Eligibility Status to EP/EH

Description:	<p>Description: The eligibility status will be posted to the Inquiry tab of the NLR to reflect the State's eligibility determination.</p> <p>Resources: CMS</p> <p>Potential Technology to Leverage: NLR</p>
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RE-020-060: Receive Eligibility Status

Description:	<p>Description: The EP or EH will receive their status from MaineCare via email (or other method if no email) Alternatively, the EP or EH may log into the NLR to check their eligibility status.</p> <p>Resources: EP or EH</p> <p>Proposed Technology to leverage: NLR, Maine OIT developed system</p>
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EP/EH determined to be eligible?

Description:	<p>If the EP/EH is determined by the State to be eligible for the EHR Incentive Program, the EP/EH will submit their payment request and attestations.</p> <p>If the EP/EH is determined by the State to be ineligible for the EHR Incentive Program, the EP/EH can appeal the eligibility determination.</p>
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Events in this process:

P-010: Submit Payment Request and Attestations

RE-010: Register EP or EH

APP-010: Appeal Eligibility, AIU, MU, and Payment Determinations

Process: Switch EP between Program and/or State Sub-Process

As of Program Year 2015 this process is no longer applicable to the Program. For historical reference this sub-process process will continue to be documented within the SMHP.

Tasks in this process:

RE-030-010: Request change in EHR Incentive Program registration

Description:	<p>Description: The EP will log into the NLR to submit a request to change the EHR Incentive Program they previously registered for. The EP will request the change by selecting the program in the appropriate fields.</p> <p>Resources: EP</p> <p>Proposed Technology to leverage: NLR</p>
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RE-030-020: Receive request to switch EHR Incentive Program registration

Description:	<p>Description: The NLR receives the request to switch EHR Incentive Program registration. If the EP is switching to the Medicare EHR Incentive Program, the NLR will do a check against death records and sanctions/licensing status and to ensure that the EP is enrolled as a Medicare provider.</p> <p>Resources: CMS</p> <p>Proposed Technology to leverage: NLR</p>
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RE-030-030: Reject Request to Switch

Description:	<p>Description: If a switch between Medicare and Medicaid programs has already occurred, the change request will be rejected.</p> <p>Resources: CMS</p> <p>Proposed Technology to leverage: NLR</p>
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RE-030-040: Notify EP of Rejection

Description:	<p>Description: CMS updates the EPs record in the NLR to show that their request to switch programs has been rejected. This information can be viewed by the EP in the Inquiry tab.</p> <p>Resources: CMS</p> <p>Proposed Technology to leverage: NLR</p>
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RE-030-050: Receive Rejection Notification

Description:	<p>Description: The EP will receive notification of the rejection of their request to switch programs by logging into the NLR and viewing the Inquiry tab.</p> <p>Resources: EP</p> <p>Proposed Technology to leverage: NLR</p>
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RE-030-060: Record switch between EHR Incentive Programs

Description:	<p>Description: If no previous switch occurred, the NLR will record the switch between EHR Incentive Programs.</p> <p>Resources: CMS</p> <p>Proposed Technology to leverage: NLR</p>
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RE-030-070: Notify State of EP's switch between EHR Incentive Programs

Description:	<p>Description: The NLR will notify the State of the EP's switch to registration in the State's Medicaid program or request to end participation in the State's Medicaid program.</p> <p>Resources: CMS</p> <p>Potential Technology to Leverage: NLR</p>
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RE-030-080: Receive Change Notification

Description:	<p>Description: MaineCare will receive a notification from the NLR of the EP's change in registration for the EHR Incentive Program.</p> <p>Resources: MaineCare Services</p> <p>Proposed Technology to leverage: Maine OIT developed system</p>
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RE-030-090: Inactivate EP

Description:	<p>Description: MaineCare will update the system to show that the EP has been inactivated from participating in the EHR Incentive Program.</p> <p>Resources: MaineCare Services</p>
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	Proposed Technology to leverage: Maine OIT developed system
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RE-030-100: Send Notification of Inactivation to the NLR

Description:	<p>Description: MaineCare will notify the NLR once the EP has been inactivated.</p> <p>Resources: MaineCare Services</p> <p>Proposed Technology to leverage: Maine OIT developed system</p>
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RE-030-110: Receive Inactivation Notice

Description:	<p>Description: The NLR will receive a notification of the inactivation of the EP from the State system.</p> <p>Resources: CMS</p> <p>Proposed Technology to Leverage: NLR</p>
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RE-030-120: Notify EP of inactivation

Description:	<p>Description: CMS updates the EPs record in the NLR to show that their registration with the State's Medicaid EHR Incentive Program has been inactivated. This information can be viewed by the EP in the Inquiry tab.</p> <p>Resources: CMS</p> <p>Proposed Technology to leverage: NLR</p>
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RE-030-130: Receive Inactivation Notification

Description:	<p>Description: The EP is notified that they have been inactivated from the State's Medicaid EHR Incentive Program by logging into the NLR and viewing the Inquiry tab.</p> <p>Resources: EP</p> <p>Proposed Technology to leverage: NLR</p>
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Gateways in this process:

First request to switch EHR Incentive Programs?

Description:	<p>Once the NLR receives the request to switch programs, the NLR will do a check to ensure that this is the first request to switch EHR Incentive Program registration.</p> <p>If this is the first request to switch programs, the EP is able to switch their registration for the EHR Incentive Program.</p> <p>If this is not the first request to switch programs and a previous request has been submitted and processed, the EP is unable to switch their registration for the EHR Incentive Program.</p>
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Did EP switch registration to State's Medicaid EHR Incentive Program?

Description:	<p>Once the State receives the information from the NLR of the EP's requested switch in the EHR Incentive Program, the State must assess if the EP's eligibility needs to be determined for participation in the program or if the EP should be inactivated in the system.</p> <p>If the EP has switched their registration to the State's Medicaid program, the state must determine the eligibility of the EP.</p> <p>If the EP has switched their registration to another State's Medicaid program or the Medicare program, the EP should be inactivated from the system.</p>
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Events in this process:

RE-020: Determine Eligibility

RE-010: Register EP or EH

Process: Submit Payment Request and Attestations Sub-Process

Tasks in this process:

P-010-020-010: Submit attestation of AIU (Application Process)

<p>Description:</p>	<p>Description: The EP or EH provides the State with their attestation of adoption, implementation, or upgrade of certified EHR technology. EPs/EHs would be required to provide the following information via the SMA’s Medicaid Eligibility worksheet:</p> <p>EHR incentive payment year – Year 1 EHR participant participating year EHR reporting period dates NPI CCN The Certified EHR Technology that the Provider uses and attestation that it is a CMS certified technology.</p> <p>Resources: EP/EH</p> <p>Proposed Technology to leverage: NLR, Maine OIT developed system</p>
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P-010-020-020: Receive attestation of AIU

<p>Description:</p>	<p>Description: MaineCare Services receives the attestation from the EP or Medicaid EH stating that they have adopted, implemented, or upgraded certified EHR technology.</p> <p>Resources: MaineCare Services</p> <p>Proposed Technology to leverage: Maine OIT developed system</p>
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P-010-020-030: Receive attestation of AIU

<p>Description:</p>	<p>Description: CMS receives the attestation from the dually eligible hospital stating that they have adopted, implemented, or upgraded certified EHR technology. CMS sends the attestation information to MaineCare.</p> <p>Resources: CMS</p> <p>Proposed Technology to leverage: NLR</p>
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P-010-020-040: Verify attestation

Description:	<p>Description: MaineCare Services verifies the attestation from the EP or EH stating that they have adopted, implemented, or upgraded certified EHR technology. The State reviews the attestation for validity and completeness, including checking the ONC list of certified EHR technology to validate that the technology that the provider attested to using is CMS certified technology.</p> <p>Resources: MaineCare Services</p> <p>Proposed Technology to leverage: Maine OIT developed system</p>
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P-010-020-050: Log attestation record

Description:	<p>Description: MaineCare logs the attestation record to the EP/EHs file for attestation history for the EHR Incentive Program. MaineCare documents all the information provided by the EP/EH in the attestation. This information is sent to the NLR.</p> <p>Resources: MaineCare Services</p> <p>Proposed Technology to leverage: Maine OIT developed system</p>
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P-010-020-060: Receive attestation record and send status to EP/EH

Description:	<p>Description: CMS receives the attestation record from MaineCare Services and logs the attestation status to the EP/EH record.</p> <p>Resources: CMS</p> <p>Proposed Technology to leverage: NLR</p>
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P-010-020-070: Receive attestation status

Description:	<p>Description: The EP or EH will receive their status from MaineCare via email (or other method if no email) Alternatively, the EP or EH may log into the NLR to check their eligibility status. Once the State determines the eligibility for the EP or EH, the Inquiry tab of the NLR will reflect the change.</p> <p>Resources: EP/EH</p> <p>Proposed Technology to leverage: NLR, Maine OIT Developed System</p>
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P-010-020-080: Notify EP/EH of rejected attestation

Description:	<p>Description: MaineCare notifies the EP/EH that the attestation has been rejected. Reasons for attestation rejection include: Invalid Format Invalid attestation reporting period More than one initial attestation for the same reporting period</p> <p>Resources: MaineCare Services</p> <p>Proposed Technology to leverage: Maine OIT Developed System</p>
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P-010-020-090: Receive notification of rejected attestation

Description:	<p>Description: The EP/EH receives electronic notification that their attestation has been rejected.</p> <p>Resources: EP/EH</p> <p>Proposed Technology to leverage: Maine OIT Developed System</p>
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Gateways in this process:

Type of Applicant

Description:	<p>The type of applicant determines what system in which the attestation is logged.</p> <p>If the applicant is a dually eligible hospital, they will log their attestation in the National Level Repository managed by CMS.</p> <p>If the applicant is an EP or Medicaid hospital, they will log their attestation in a State system.</p>
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Attestation received and valid?

Description:	<p>Based on the attestation status, the EP/EH has a few options.</p> <p>If the attestation is rejected, the EP/EH will have to resubmit their attestations to the State or to the NLR.</p> <p>If the attestations are deemed invalid by the State, the EP/EH can appeal the attestation determination.</p>
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	If the attestation is received and valid, MaineCare services will initiate the verify eligibility process to determine if the EP/EH is eligible to receive an incentive payment.
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Events in this process:

APP-010: Appeal Eligibility, AIU, MU, and Payment Determinations

P-010-040: Receive Payment Request and Attestations

P-010-010: Submit Payment Request and Attestations

Process: Submit Adoption, Implementation or Upgrade of Certified EHR Technology Attestations Sub-Activity

Tasks in this process:

P-010-010: Submit Payment Request and Attestations

Description:	<p>Description: An EP or EH will submit the Medicaid eligibility worksheet and their attestations.</p> <p>Resources: EP or EH</p> <p>Potential Technology to Leverage: Maine OIT Developed System</p>
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P-010-040: Receive Payment Request and Attestations

Description:	<p>Description: MaineCare will receive the Medicaid eligibility worksheet and attestation data provided by the EP/EH.</p> <p>Resources: MaineCare Services</p> <p>Potential Technology to Leverage: Maine OIT Developed System</p>
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P-010-050: Log Payment Request

Description:	<p>Description: MaineCare will log the submitted data in the State system.</p> <p>Resources: MaineCare Services</p> <p>Potential Technology to Leverage: Maine OIT Developed System</p>
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Gateways in this process:

Participation Year?

Description:	<p>The EP or EH must provide different attestations depending on the year of participation in the EHR Incentive Program.</p> <p>If the EP or EH is providing an attestation for Year 1 of participation in the EHR Incentive Program, they may attest to adopting, upgrading, or implementing certified EHR technology or they can attest to Meaningful Use of Certified EHR technology as proscribed by CMS rules.</p> <p>For Years 2 and thereafter EPs and Medicaid only hospitals must also attest to Meaningful Use of certified EHR technology as proscribed by CMS rules (expected in 2011 and updates thereafter.) Dually-eligible hospitals will submit MU to CMS.</p>
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Events in this process: P-020: Verify Eligibility, RE-020: Determine Eligibility

Process: MU Attestation**Tasks in this process:**

P-010-030-010: Submit attestation of Meaningful Use

Description:	<p>Description: The EP or EH logs into a system to provide the State with their attestation of Meaningful Use as defined by CMS Final Rule, as amended by the CMS Flexibility Rule which has been implemented by the State:</p> <p>When an EP or EH registers for a Meaningful Use payment, MaineCare sends the EP or EH a Medicaid eligibility worksheet to complete and submit. The worksheet was updated in October 2014 with the following language explaining available options acceptable under the Flexibility Rule and reasons for use of the option:</p> <p><u>CEHRT options for Stage 1 2014</u></p> <p>Please choose what CEHRT you are submitting for 2014 from these 3 options:</p> <ol style="list-style-type: none"> 1. - 2011 CEHRT with 2013 MU definition 2. - 2014 CEHRT with 2014 MU definition 3. - Combination 2011/2014 CEHRT with 2013 MU definition <p>* If you are due to submit stage 2 in 2014 but will submit a third year of Stage 1-please indicate if you are using 2013 or 2014 MU definition. (See link)</p> <p>Provide an explanation why 2014 Edition CEHRT was not fully implemented in the organizations with a list of implementation actions that could not be accomplished due to vendor delays. If you have documentation from your vendor please forward that with this worksheet.</p> <p>CMS approved acceptable reasons for need to use the CEHRT option:</p> <ul style="list-style-type: none"> • Software development delays • Missing or delayed software updates • Being able to implement 2014 CEHRT for part of the reporting period (not the full reporting period) • Unable to train staff, test the updates system, or put new workflows in place due to delay with installation of 2014 CEHRT • Cannot meet Stage 2 Summary of Care measures due to the recipient of their Summary of Care transmittal being impacted by 2014 CEHRT issues. The sending provider may experience significant difficulty
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meeting the 10% threshold for electronic transmissions, despite the referring provider's ability to send the electronic document, if the intermediary or the recipient of the transition or referral is experiencing delays in the ability to fully implement 2014 Edition CEHRT

The Rule specifically states that the following are NOT acceptable reasons for NOT being able to fully implement:

- Financial issues
- Inability to meet one or more measures
- Staff turnover and change
- Provider waited too long to engage a vendor
- Refusal to purchase the requisite software
- Providers who fully implemented 2014 Edition CEHRT and can report in 2014

We strongly advise you keep documentation in your records to support your eligibility to utilize the CEHRT options.

Excerpt of CMS CEHRT Rule:

EHR Incentive Programs 2014 CEHRT Rule:

On August 29, 2014 CMS and ONC released a final rule that allows providers participating in the EHR Incentive Programs to use the 2011 Edition of certified electronic health record technology (CEHRT) for calendar and fiscal year 2014.

The rule grants flexibility to providers who are unable to fully implement 2014 Edition CEHRT for an EHR reporting period in 2014 due to delays in 2014 CEHRT availability. Providers may now use EHRs that have been certified under the 2011 Edition, a combination of the 2011 and 2014 Editions, or the 2014 Edition for 2014 participation. Beginning in 2015, all eligible providers will be required to report using 2014 Edition CEHRT.

2014 Participation Options

Under the rule, you may use 2011 Edition CEHRT, and you have the option to attest to the 2013 Stage 1 objectives and the 2013 definition CQMs.

Below are the participation options for 2014 based on the Edition of EHR certification you are currently using:

2011 CEHRT

If you are scheduled to report Stage 1 or Stage 2:

	<p>2013 Stage 1 objectives and 2013 CQMs</p> <p><u>Combination of 2011 & 2014 CEHRT</u></p> <p>If you are scheduled to report Stage 1: 2013 Stage 1 objectives and 2013 CQMs; or 2014 Stage 1 objectives and 2014 CQMs</p> <p>If you are scheduled to report Stage 2: 2013 Stage 1 objectives and 2013 CQMs; or 2014 Stage 1 objectives and 2014 CQMs; or Stage 2 objectives and 2014 CQMs</p> <p><u>2014 CEHRT</u></p> <p>If you are scheduled to report Stage 1: 2014 Stage 1 objectives and 2014 CQMs</p> <p>If you are scheduled to report Stage 2: Stage 2 objectives and 2014 CQMs; or 2014 Stage 1 objectives and 2014 CQMs</p> <p><u>Modified Stage 2 Meaningful Use 2015-2017</u></p> <p>If you are scheduled to report Stage 1 Modified 2015-2017 Stage 1 Objectives and 2014 CQMs</p> <p>If you are scheduled to report Stage 2 Modified 2015-2017 Stage 2 Objectives and 2014 CQMs</p> <p>Resources: EP/EH</p> <p>Proposed Technology to leverage: Maine OIT Developed System</p>
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P-010-030-020: Receive attestation of Meaningful Use

Description:	<p>Description: MaineCare Services receives the attestation from the EP or Medicaid EH of Meaningful Use and the clinical quality measures.</p> <p>Resources: MaineCare Services</p> <p>Proposed Technology to leverage: Maine OIT Developed System</p>
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P-010-030-030: Receive attestation of Meaningful Use

Description:	<p>Description: CMS receives the attestation from the dually eligible hospital of Meaningful Use and the clinical quality measures. CMS sends the attestation information to MaineCare Services for their records.</p> <p>Resources: CMS</p> <p>Proposed Technology to leverage: NLR, Maine OIT Developed System</p>
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8P-010-030-040: Verify attestation

Description:	<p>Description: MaineCare Services verifies the attestation from the EP or EH that Meaningful Use and the clinical quality measures for validity and completeness.</p> <p>Resources: MaineCare Services</p> <p>Proposed Technology to leverage: Maine OIT Developed System</p>
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P-010-030-050: Log attestation record

Description:	<p>Description: MaineCare Services logs the attestation record to the EP/EHs file for attestation history for the EHR Incentive Program. MaineCare documents all the information provided by the EP/EH in the attestation.</p> <p>Resources: MaineCare Services</p> <p>Proposed Technology to leverage: Maine OIT Developed System</p>
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P-010-030-060: Receive attestation record and send status to EP/EH

Description:	<p>Description: CMS receives the attestation record from MaineCare Services and logs the attestation status to the EP/EH record.</p> <p>Resources: MaineCare Services, CMS</p> <p>Proposed Technology to leverage: NLR, Maine OIT Developed System</p>
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P-010-030-070: Receive attestation status

Description:	<p>Description: The EP or EH will receive their status from MaineCare via email (or other method if no email) Alternatively, the EP or EH may log into the NLR to check their status.</p>
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	Resources: EP/EH Proposed Technology to leverage: NLR
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P-010-030-080: Notify EP/EH of rejected attestation

Description:	Description: MaineCare notifies the EP/EH that the attestation has been rejected. Reasons for attestation rejection include: Invalid Format Invalid attestation reporting period More than one initial attestation for the same reporting period Non-compliance with Meaningful Use measures as established by CMS rules. Resources: MaineCare Services Proposed Technology to leverage: Maine OIT Developed System
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P-010-030-090: Receive notification of rejected attestation

Description:	Description: The EP/EH receives electronic notification that their attestation has been rejected. Resources: EP/EH Proposed Technology to leverage: Maine OIT Developed System
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Gateways in this process:

Type of Applicant

Description:	The type of applicant determines what system in which the attestation is logged. If the applicant is a dually eligible hospital, they will log their attestation in the National Level Repository managed by CMS. If the applicant is an EP or Medicaid hospital, they will log their attestation in a State system.
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Attestation received and valid?

Description:	Based on the attestation status, the EP/EH has a few options. If the attestation is rejected, the EP/EH will have to resubmit their attestations to the State or to the NLR.
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	<p>If the attestations are deemed invalid by the State, the EP/EH can appeal the decision. (Dually-eligible hospitals cannot appeal MU, which must be done through CMS.)</p> <p>If the attestation is received and valid, MaineCare services will initiate the verify eligibility process to determine if the EP/EH is eligible to receive an incentive payment.</p>
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Events in this process:

- P-010-010: Submit Payment Request and Attestations
- P-010-040: Receive Payment Request and Attestations
- APP-010: Appeal Eligibility, AIU, MU, and Payment Determination

Process: Verify Eligibility

Tasks in this process:

P-020-010: Request hospital registration status

Description:	<p>Description: MaineCare will request the hospital's registration status for the EHR Incentive Programs from CMS via the NLR.</p> <p>Resources: MaineCare Services</p> <p>Proposed Technology to leverage: Maine OIT Developed System</p>
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P-020-020: Receive request for hospital registration status

Description:	<p>Description: CMS will receive the request from MaineCare for the hospital's registration status for the EHR Incentive Programs via the NLR.</p> <p>Resources: CMS</p> <p>Proposed Technology to leverage: NLR</p>
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P-020-030: Send hospital registration status

Description:	<p>Description: CMS will send the hospital's registration status for the EHR Incentive Programs to MaineCare Services via the NLR.</p> <p>Resources: CMS</p> <p>Proposed Technology to leverage: NLR</p>
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P-020-040: Receive hospital registration status

Description:	<p>Description: MaineCare Services will receive the hospital's registration status for the EHR Incentive Programs to MaineCare Services from CMS via the NLR.</p> <p>Resources: MaineCare Services</p> <p>Proposed Technology to leverage: Maine OIT Developed System</p>
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P-020-050: Verify Eligibility and Attestation Requirements

Description:	<p>Description: MaineCare will check the eligibility status of EPs and EHS to ensure that their attestations have been received and are valid before</p>
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	<p>processing payment. MaineCare will verify the following information:</p> <ul style="list-style-type: none"> - State eligibility status, including patient volume requirements, "practices predominantly" requirements, death records, licenses, sanctions - Adoption, Implementation or Upgrade to EHR technology attestation or Meaningful Use and clinical quality measures attestations - Hospital registration in PECOS (EHs only) <p>Resources: MaineCare Services</p> <p>Proposed Technology to leverage: Maine OIT Developed System, MIHMS Provider portal, Licensing, All Claims Database, MIHMS claims system</p>
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P-020-060: Send data request to check payment history

<p>Description:</p>	<p>Description: MaineCare sends a data request to the National Level Repository to check for payments from other states or other exclusions from the EHR Incentive Program.</p> <p>Resources: MaineCare Services</p> <p>Proposed Technology to leverage: Maine OIT Developed System</p>
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P-020-070: Search payment history

<p>Description:</p>	<p>Description: The NLR will search for the EP/EH payment history to ensure that the EP/EH has not received a payment from the Medicare program, a payment from another state's Medicaid program, or is excluded from receiving an incentive payment from the EHR Incentive Program. The NLR will also check for any sanctions against the provider as well as death files to ensure that the provider may receive a payment. This activity prevents an EP/EH from receiving a duplicate payment. Note: EHs can receive a Medicare and Medicaid payment.</p> <p>Resources: CMS</p> <p>Proposed Technology to leverage: NLR</p>
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P-020-080: Send Payment History

<p>Description:</p>	<p>Description: The NLR will send the EP/EH payment history to MaineCare.</p> <p>Resources: CMS</p>
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	Proposed Technology to leverage: NLR
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P-020-090: Receive Payment History

Description:	<p>Description: MaineCare will receive the provider or hospital payment record from the NLR. MaineCare will review the payment history to ensure that the EP has not received a Medicare payment; or for EP and EHs, payment from another state's Medicaid program; or is excluded from receiving an incentive payment from the EHR Incentive Program. This activity prevents an EP/EH from receiving a duplicate payment.</p> <p>Resources: MaineCare Services</p> <p>Proposed Technology to leverage: Maine OIT Developed System</p>
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P-020-100: Generate Payment Denial Notice

Description:	<p>Description: A payment denial notice is generated indicating that the EP's or EH's eligibility for payment has been denied or attestation requirements have not been met and an incentive payment will not be issued.</p> <p>Resources: MaineCare Services</p> <p>Proposed Technology to leverage: Maine OIT Developed System</p>
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P-020-110: Notify NLR of Payment Denial

Description:	<p>Description: MaineCare sends a notification to the NLR that the EP/EH eligibility has been denied or attestation requirements have not been met and an incentive payment will not be issued.</p> <p>Resources: MaineCare Services</p> <p>Proposed Technology to leverage: Maine OIT Developed System</p>
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P-020-120: Update Payment History

Description:	<p>Description: CMS will update the EP's or EH's payment history to reflect payment denial.</p> <p>Resources: CMS</p> <p>Proposed Technology to leverage: NLR</p>
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P-020-130: Notify EP or EH

Description:	<p>Description: CMS will post the payment denial on the Inquiry tab of the NLR.</p> <p>Resources: CMS</p> <p>Proposed Technology to leverage: NLR</p>
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P-020-140: Receive Payment Denial Notification

Description:	<p>Description: The EP or EH will receive their status from MaineCare via email (or other method if no email) Alternatively, the EP or EH may log into the NLR to check their status.</p> <p>Resources: EP/EH</p> <p>Proposed Technology to leverage: NLR</p>
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Gateways in this process:

Does EP/EH Meet Eligibility and Attestation Requirements?

Description:	<p>The EP/EH must meet the eligibility and attestation requirements to receive a payment.</p> <p>If the EP/EH does meet the eligibility and attestation requirements, MaineCare will continue the payment process.</p> <p>If the EP/EH does not meet the eligibility and attestation requirements, MaineCare will issue a payment denial notice.</p>
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Has the EP/EH already received a payment?

Description:	<p>MaineCare reviews the payment history to ensure that the EP/EH has not received a Medicare payment or a payment from another state's Medicaid program, or is excluded from receiving an incentive payment from the EHR Incentive Program.</p> <p>If the EP has not received a payment from Medicare or in the case of EPs and EHs, another state for the participation year, MaineCare will move forward and adjudicate the incentive payment.</p> <p>If the EP has already received a payment from Medicare or if the EP or EH received a payment from another state for the participation year, MaineCare will issue a payment denial notice.</p>
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	Note: EHs can receive a Medicare and Medicaid payment.
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Payment denial valid?

Description:	If the EP/EH agrees that the payment denial was valid, they can resubmit their payment request and attestations with the complete and valid information to receive an incentive payment. If the EP/EH disagrees with the payment denial, the EP can appeal the payment denial.
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Events in this process:

- P-010: Submit Payment Request and Attestations
- P-030: Adjudicate Payment
- APP-010: Appeal Eligibility, AIU, MU, and Payment Determinations
- P-010: Submit Payment Request and Attestations

Process: Adjudicate Payment

Swim Lane	Description
CMS	Centers for Medicare & Medicaid Services (CMS) is the US Federal agency which administers Medicare, Medicaid, and the Children's Health Insurance Program. CMS is responsible for overseeing the Medicare and Medicaid EHR Incentive Programs. CMS will monitor State Medicaid Agency EHR Incentive Programs through mandatory reporting. CMS will also maintain the National Level Repository (NLR), the system that will facilitate and capture EP and Hospital registration for the Medicare and Medicaid EHR Incentive Programs.
DHHS Finance	DHHS Finance is the entity that issues payment to eligible professionals and eligible hospitals for the Maine Medicaid EHR Incentive Program.
Office of MaineCare Services	The Office of MaineCare Services (OMS) is the entity responsible for administering and overseeing the Maine Medicaid EHR Incentive Program.
Eligible Professionals (EPs) or Eligible Hospitals (EHs)	<p>An Eligible Professional (EP) in the Medicaid EHR Incentive Program is defined as a physician, a dentist, a certified nurse-midwife, a nurse practitioner, or a physician assistant who is practicing predominantly in a Federally Qualified Health Center (FQHC) led by a physician assistant, or a Rural Health Clinic (RHC) led by a physician assistant. EPs must meet the 30% (at least 20% if pediatrician) Medicaid patient volume requirements and cannot be hospital-based professionals as defined in the Final Rule as providing substantially all (more than 90%) of their clinical activity in an inpatient or emergency room setting.</p> <p>Eligible hospitals (EH) for the Medicaid EHR Incentive Program include Acute Care and Children's Hospitals. To be eligible for a Medicaid EHR incentive payment, Acute Care Hospitals must have at least a 10% patient volume attributable to Medicaid (Title XIX). Children's Hospitals do not have patient volume requirements under Medicaid. Hospitals are eligible to receive both Medicare and Medicaid EHR Incentive payments in the same year.</p>
Entity who may receive the EP/EH's incentive payment (Reassigned)	An entity may be the employer or biller for an EP/EH that has a voluntary contractual relationship to be designated by the EP /EH to receive the EP/EH incentive payments. The final rule also allows states to designate an entity promoting the adoption of certified EHR technology by enabling oversight of the business, operational, and legal issues involved in the adoption and implementation of certified EHR technology or by enabling the exchange and

	use of electronic clinical and administrative data between participating providers, in a secure manner, including maintaining the physical and organizational relationship integral to the adoption of certified EHR technology by eligible providers. Maine does not have any State-designated entities.
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P-030-010: Execute Payment Trigger

Description:	<p>Description: The payment trigger can be executed by en mass or by individual payment requests.</p> <p>Resources: MaineCare Services</p> <p>Proposed Technology to leverage: Maine OIT Developed System</p>
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P-030-020: Review Payment Requests

Description:	<p>Description: MaineCare reviews the payment requests to validate EP or EH information and verifying the frequency of payments to ensure that the EP or EH has not already received a payment for that year. Participation year follows the calendar year for EPs and the Federal Fiscal Year for EHs. EHs will follow the calendar year per the 2015-2017 modification rule.</p> <p>Resources: MaineCare Services</p> <p>Proposed Technology to leverage: Maine OIT Developed System</p>
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P-030-030: Perform Adjudication and Calculate Payment

Description:	<p>Description: Adjudicate the payment by setting the payment request to "pay" or "deny" status for the EP or the EH.</p> <p>For EP incentive payments: According to CMS' guidance on the Medicare and Medicaid Extenders Act of 2010, payments of \$21,250 the first year, and payments of \$8,500 for years 2 through 6 will be made.</p> <p>For EH incentive payments: MaineCare will verify hospital incentive payment calculations based on the hospital's Medicare cost reports and audited financial statements. For charity care, the Department used the bad debts and free care from the hospital's audited financial statement, and then subtracted the reimbursable bad debts from the Medicare cost report.</p> <p>Resources: MaineCare Services</p>
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	Proposed Technology to leverage: Maine OIT Developed System
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P-030-040: Create Payment File

Description:	<p>Description: Create a payment file to be sent to AdvantageME to process the incentive payment.</p> <p>Resources: MaineCare Services</p> <p>Proposed Technology to leverage: Maine OIT Developed System (Flexi Financial)</p>
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P-030-050: Process Payment File and Make Payment

Description:	<p>Description: The payment file is processed, DHHS Finance draws down ARRA funds and the incentive payment is sent to the EP or EH.</p> <p>Resources: DHHS Finance</p> <p>Proposed Technology to leverage: AdvantageME</p>
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P-030-060: Create Feedback File

Description:	<p>Description: Once the payment is processed and paid to the EP/EH, a feedback file is created and sent to MaineCare.</p> <p>Resources: DHHS Finance</p> <p>Proposed Technology to leverage: Advantage ME</p>
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P-030-070: Receive Payment

Description:	<p>Description: The EP or EH receives the incentive payment. This could be done manually via a paper based check or electronically via EFT.</p> <p>Resources: EP or EH</p> <p>Proposed Technology to Leverage: AdvantageME, EFT</p>
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P-030-080: EP/EH Retains Payment

Description:	Description: EP or EH retains the incentive payment.
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	<p>Resources: EP or EH</p> <p>Proposed Technology to leverage: None identified at this time</p>
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P-030-090: Payments that have been reassigned by the EP/EH to another entity

Description:	<p>Description: EP or EHs may reassign their payment to an employer or entity which provides billing services. This reassignment is done through the NLR process by listing the TIN of the “reassigned.” The payments, when they are processed through AdvantageME will be made to the assignee’s TIN/address. (The other option of reassigning the payment to a State-designated entity is not available at this time in Maine.)</p> <p>Resources: EP/EH</p> <p>Proposed Technology to leverage: None identified at this time</p>
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P-030-120: Update Payment File

Description:	<p>Description: Upon receipt of the payment feedback file from DHHS Finance or receipt of payment use from an EP or EH, MaineCare will update the payment file to indicate the amount paid, date, and designation of the incentive payment.</p> <p>Resources: MaineCare Services</p> <p>Proposed Technology to leverage: (FlexiFinancial) Maine OIT Developed System</p>
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P-030-130: Notify CMS of Payment

Description:	<p>Description: MaineCare will notify CMS through the NLR that an incentive payment was made to an EP or EH.</p> <p>Resources: MaineCare Services</p> <p>Proposed Technology to leverage: Maine OIT Developed System</p>
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P-030-140: Update Payment History

Description:	<p>Description: CMS will update the EP's or EH's payment history. This data will include the amount of the incentive payment, the state that issued the incentive payment, the date, and if the incentive payment was made by the</p>
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	<p>EP or EH or reassigned as allowed by CMS.</p> <p>Resources: CMS</p> <p>Proposed Technology to leverage: NLR</p>
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P-030-150: Notify EP or EH

Description:	<p>Description: MaineCare will notify the EP/EH with information that reflects the date of payment and the payment amount.</p> <p>Resources: CMS</p> <p>Proposed Technology to leverage: NLR, Maine OIT Developed System</p>
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P-030-160: Receive Payment Notification

Description:	<p>Description: In addition to getting OMS notification, The EP or EH may log into the NLR and navigate to the Inquiry tab to view their payment history.</p> <p>Resources: EP or EH</p> <p>Proposed Technology to leverage: NLR</p>
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Gateways in this process:

Payment Amount Correct?

Description:	<p>If the EP/EH agrees that the payment amount was correct, the payment process is complete.</p> <p>If the EP/EH disagrees with the payment amount received, the EP/EH can appeal the payment amount.</p>
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Events in this process:

P-020: Verify Eligibility

APP-010: Appeal Eligibility, AIU, MU, and Payment Determinations

Process: Manage Recoupment

Tasks in this process:

P-040-010: Initiate Recoupment Request

<p>Description:</p>	<p>Description: Incentive payment recoupments are initiated by the discovery of an overpayment--for example, an HIT Incentive Payment audit or receipt of notice from the NLR via the payment history file or for situations where monies are owed to the agency due to fraud/abuse, or EH/EPs owed funds from a Federal or State audit, or from a Medicaid overpayment, or from a review by the HIT specialist, or from a request from the EP/EH for recoupment. The HIT specialist will create a recoupment file and invoice and submit to the DHHS finance division, which will include the following:</p> <ul style="list-style-type: none"> NPI TIN Program Year Record Number Payment Amount State Provider Type Exclusion Indicator Exclusion Type Exclusion Description Business Classification State- where sanctions are effective Date range of the exclusion Contact information for the EP/EH Notes <p>Resources: MaineCare Services</p> <p>Proposed Technology to leverage: Maine OIT Developed System</p>
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P-040-020: Notify EP or EH of Recoupment

<p>Description:</p>	<p>Description: DHHS Finance will create and send a notification to the EP or EH to request that they pay the State the amount of the overpayment. Information listed in the notification includes:</p> <ul style="list-style-type: none"> NPI TIN Program Year Record Number
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	Payment Amount State Provider Type Exclusion Indicator Exclusion Type Exclusion Description Business Classification State- where sanctions are effective Date range of the exclusion Notes Resources: MaineCare Services Proposed Technology to leverage: None identified at this time
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P-040-030: Receive Notification

Description:	Description: EP or EH receives recoupment request notification. Resources: EP or EH Proposed Technology to leverage: None identified at this time
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P-040-040: Verify Overpayment/Duplicate Payment

Description:	Description: EP or EH will verify with their own records and payment system to verify that an overpayment or duplicate payment was made. Resources: EP or EH Proposed Technology to leverage: None identified at this time
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P-040-050: Cut Check

Description:	Description: The EP or EH issues a check for the amount of the overpayment or duplicate payment to MaineCare. Resources: EP or EH Proposed Technology to leverage: None identified at this time
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P-040-060: Generate Receipt

Description:	Description: EP or EH will generate a receipt for the issuance of funds to
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	<p>MaineCare for the overpayment or duplicate payment.</p> <p>Resources: EP or EH</p> <p>Proposed Technology to leverage: Maine OIT Developed System</p>
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P-040-070: Send Payment and Receipt

Description:	<p>Description: EP or EH sends the payment reimbursement and receipt to MaineCare.</p> <p>Resources: EP or EH</p> <p>Proposed Technology to leverage: None identified at this time</p>
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P-040-080: Apply Recoupment in System

Description:	<p>Description: DHHS Finance performs the accounting function in the State system for the recoup payment. DHHS Finance reports the recoupment to CMS.</p> <p>Resources: DHHS Finance</p> <p>Proposed Technology to leverage: AdvantageME</p>
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P-040-090: Notification of Recoupment

Description:	<p>Description: HIT Specialist updates the EP's or EH's payment history in the SLR.</p> <p>Resources: MaineCare Services</p> <p>Proposed Technology to leverage: Maine OIT Developed System</p>
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P-040-100: Update Payment History

Description:	<p>Description: MaineCare will update the payment history by indicating that the overpayment or duplicate payment has been recouped.</p> <p>Resources: MaineCare Services</p> <p>Proposed Technology to leverage: Maine OIT Developed System, MIHMS</p>
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P-040-110: Send Payment and History

Description:	<p>Description: MaineCare will send the payment and updated payment history to CMS via the NLR.</p> <p>Resources: MaineCare Services</p> <p>Proposed Technology to leverage: NLR</p>
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P-040-120: Receive Payment Resolution Report

Description:	<p>Description: CMS will receive payment and payment history.</p> <p>Resources: CMS</p> <p>Proposed Technology to leverage: NLR</p>
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P-040-130: Notify EP or EH of Recoupment Status

Description:	<p>Description: CMS will notify the EP or EH that the overpayment or duplicate payment has been recouped and received by CMS. The payment history will be updated on the Inquiry tab of the NLR.</p> <p>Resources: CMS</p> <p>Proposed Technology to leverage: NLR</p>
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P-040-140: Receive Notification

Description:	<p>Description: The EP or EH will receive notice of the receipt of recoupment by viewing their payment history which can be found on the Inquiry tab on the NLR.</p> <p>Resources: EP or EH</p> <p>Proposed Technology to leverage: NLR</p>
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Gateways in this process:

Is Recoupment Request Valid?

Description:	<p>If the EP/EH believes that the recoupment request is valid, the EP/EH issues the overpayment or duplicate payment amount to MaineCare.</p> <p>If the EP/EH believes that the recoupment request is invalid, the EP/EH can appeal the payment or payment amount requested by MaineCare.</p>
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What Type of Recoupment?

Description:	Once the recoupment record is created, MaineCare will determine if they will request a direct payment from the EP or EH or if they will apply the recoupment as an adjustment to future incentive or other type of payments/reimbursements.
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Events in this process:

AUD-040: Audit Incentive Payments

APP-010: Appeal Eligibility, AIU, MU, and Payment Determinations

P-020-040: Send Payment History

Process: Appeals Sub Process

Tasks in this process:

APP-010-010: Request Informal Review

Description:	<p>Description: An EP or EH may make an appeal based on an eligibility determination, AIU attestation determination, MU attestation determination (EPs and Medicaid Hospitals only), incentive payment, or an audit of any of those items. A request for an informal review may be done through writing a letter to MaineCare within 60 days of receipt of the original notification.</p> <p>Resources: EP or EH</p> <p>Proposed Technology to leverage: None identified at this time</p>
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APP-010-020: Receive Informal Review Request

Description:	<p>Description: MaineCare will receive the request from an EP or EH for an informal review.</p> <p>Resources: MaineCare Services</p> <p>Proposed Technology to leverage: None identified at this time</p>
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APP-010-030: Track Request

Description:	<p>Description: Once the request for an informal review is received, MaineCare will track the request.</p> <p>Resources: MaineCare Services</p> <p>Proposed Technology to leverage: None identified at this time</p>
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APP-010-040: Conduct an Informal Review

Description:	<p>Description: MaineCare performs the informal review by reviewing documentation sent in by the EP or EH, cross-checking state systems for eligibility, incentive payment determinations and amounts, attestation information gathered through an audit, and incentive program policy to make a determination on whether to uphold or reverse the MaineCare decision.</p> <p>Resources: MaineCare Services</p>
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	Proposed Technology to leverage: MIHMS, NLR, Maine OIT Developed System
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APP-010-050: Reverse MaineCare Decision

Description:	<p>Description: The eligibility, incentive payment, or attestation decision is reversed. Based on the type of appeal, the EP/EH could be determined eligible for the incentive program, receive an incentive payment, or have their attestations accepted.</p> <p>Resources: MaineCare Services</p> <p>Proposed Technology to leverage: None identified at this time</p>
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APP-010-060: Send Notification to EP or EH

Description:	<p>Description: If the informal review decision is to uphold the OMS original decision, a decision letter is sent to the EP or EH notifying them of the decision and appeal rights.</p> <p>Resources: MaineCare Services</p> <p>Proposed Technology to leverage: None identified at this time</p>
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APP-010-070: Receive Notification

Description:	<p>Description: The EP or EH receives notification of the decision made based on their request for an informal review.</p> <p>Resources: EPs or EHs</p> <p>Proposed Technology to leverage: None identified at this time</p>
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APP-010-080: Request Administrative Hearing

Description:	<p>Description: The EP or EH decides not to accept the decision made through the informal review and requests an administrative hearing. The EP or EH may request an administrative hearing through writing a letter to the Commissioner of DHHS. Office of MaineCare Services.</p> <p>Resources: EP or EH</p> <p>Proposed Technology to leverage: None identified at this time</p>
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APP-010-090: Receive Administrative Hearing Request

Description:	<p>Description: The Hearings Office receives the administrative hearing request.</p> <p>Resources: DHHS</p> <p>Proposed Technology to leverage: None identified at this time</p>
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APP-010-100: Gather Documentation

Description:	<p>Description: MaineCare will gather all relevant documentation on the case. Documentation may include information from the system on eligibility determinations, attestations, incentive payments, information provided by the EP or EH, and any relevant documentation gathered from an audit.</p> <p>Resources: MaineCare Services</p> <p>Proposed Technology to leverage: MIHMS, NLR, Maine OIT Developed System</p>
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APP-010-110: Send Administrative Hearing Request and Documentation

Description:	<p>Description: MaineCare sends all relevant documentation to the Office of Administrative Hearings within the DHHS Commissioner's Office.</p> <p>Resources: MaineCare Services</p> <p>Proposed Technology to leverage: None identified at this time</p>
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APP-010-120: Receive Administrative Hearing Request

Description:	<p>Description: The Office of Administrative Hearings receives the administrative hearing request and all supporting documentation from MaineCare (or directly from the provider).</p> <p>Resources: Office of Administrative Hearings</p> <p>Proposed Technology to leverage: None identified at this time</p>
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APP-010-130: Assign Hearing Officer

Description:	<p>Description: A DHHS Hearing Officer is assigned to the case.</p>
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	<p>Resources: Office of Administrative Hearings, DHHS Hearing Officer</p> <p>Proposed Technology to leverage: None identified at this time</p>
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APP-010-140: Create Hearing Case

Description:	<p>Description: The DHHS Hearing Officer creates hearing case by reviewing all relevant information and program policy.</p> <p>Resources: Office of Administrative Hearings, DHHS Hearing Officer</p> <p>Proposed Technology to leverage: None identified at this time</p>
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APP-010-150: Conduct Administrative Hearing

Description:	<p>Description: An administrative hearing is conducted in which representatives from MaineCare and the EP or EH have the opportunity to present his/her case with supporting evidence. Hearings are generally held at the regional DHHS offices throughout the State.</p> <p>Resource: Office of Administrative Hearings, DHHS Hearing Officer, MaineCare Services, EP or EH</p> <p>Proposed Technology to leverage: None identified at this time</p>
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APP-010-160: Make Recommendation to DHHS Commissioner

Description:	<p>Description: The DHHS Hearing Officer reviews the case and all supporting documentation. The DHHS Hearing Officer makes a recommendation to the DHHS Commissioner to either uphold the MaineCare decision, modify it, or reverse the MaineCare decision. The DHHS Hearing Officer will provide MaineCare and the EP or EH with a copy of his/her recommendation. Once they receive a copy of the recommendation, MaineCare and the EP or EH have 10 days to send a letter to the DHHS Commissioner to state their case.</p> <p>Resource: Office of Administrative Hearings, DHHS Hearing Officer, MaineCare Services, EP or EH</p> <p>Proposed Technology to leverage: None identified at this time</p>
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APP-010-170: Receive and Review Administrative Hearing Case

Description:	<p>Descriptions: The DHHS Commissioner receives and reviews the</p>
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	<p>administrative hearing case and recommendation.</p> <p>Resources: DHHS Commissioner</p> <p>Proposed Technology to leverage: None identified at this time</p>
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APP-010-180: Make Ruling

Description:	<p>Description: The DHHS Commissioner decides the ruling for the case.</p> <p>Resources: DHHS Commissioner</p> <p>Proposed Technology to leverage: None identified at this time</p>
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APP-010-190: Notify MaineCare

Description:	<p>Description: The Office of Administrative Hearings notifies MaineCare of the ruling and MaineCare analyzes it to consider any program changes that may need to be made.</p> <p>Resources: Office of Administrative Hearings, OMS</p> <p>Proposed Technology to leverage: None identified at this time</p>
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APP-010-200: Notify EP/EH

Description:	<p>Description: The Office of Administrative Hearings notifies the EP or EH of the ruling on the case. This may be done via a written letter and email.</p> <p>Resource: Office of Administrative Hearings</p> <p>Proposed Technology to leverage: None identified at this time</p>
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APP-010-210: Receive Notification

Description:	<p>Description: The EP or EH receives notification of the ruling from the administrative hearing.</p> <p>Resources: Office of Administrative Hearings, EPs or EHs</p> <p>Proposed Technology to leverage: None identified at this time</p>
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APP-010-220: Request Superior Court Hearing

Description:	<p>Description: The EP or EH appeals the ruling and requests a Superior Court Hearing and uses the rules of the court.</p>
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	Resources: EPs or EHs Proposed Technology to leverage: None identified at this time
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APP-010-230: Receive Notification

Description:	Description: MaineCare receives the Superior Court hearing request and processes it in manner that is in line with current procedures. Resources: MaineCare Services Proposed Technology to leverage: None identified at this time
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Gateways in this process:

Uphold MaineCare decision?

Description:	MaineCare decides whether to uphold their original determination or reverse the original decision.
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EP or EH accepts informal review decision?

Description:	The EP or EH decides whether or not to accept the decision made through the informal review by MaineCare. EPs and EHs have the option of either accepting the decision to uphold the original determination or request an administrative hearing to appeal the determination.
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EP or EH accepts administrative hearing ruling?

Description:	The EP or EH decides on whether or not to accept the administrative hearing decision. If not, they may appeal the ruling made by the DHHS Commissioner to Maine Superior Court.
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Events in this process:

- RE-020: Determine Eligibility
- P-030: Adjudicate Payment
- AUD-040: Audit Incentive Payments
- AUD-020: Audit AIU of EHR Technology
- P-040: Manage Recoupment
- AUD-010: Audit Eligibility Determinations
- AUD-030: Audit Meaningful Use

Process: Annual CMS Report**Tasks in this process:**

R-010-010: Query Incentive Program data from data sources

Description:	<p>Description: MaineCare will query data from the State system(s) that house data on the EHR Incentive Program including information on EPs/EHs who have received an incentive payment for AIU or MU of certified EHR technology, provider AIU of certified EHR technology, data representing the EPs/EHs clinical quality measures data, and data on how the incentive program addressed individuals with unique needs such as children.</p> <p>Resources: MaineCare Services</p> <p>Proposed Technology to leverage: Maine OIT Developed System and other systems and sources</p>
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R-010-020: Query data on EP/EH qualified for incentive payment for AIU

Description:	<p>Description: MaineCare will query a list of all EPs and EHs who qualified for an incentive payment on the basis of AIU certified EHR technology. This query would also capture the provider type and practice location.</p> <p>Resources: MaineCare Services</p> <p>Proposed Technology to leverage: Maine OIT Developed System and other systems and sources</p>
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R-010-030: Query data on EP/EH qualified for incentive payment for MU

Description:	<p>Description: MaineCare will query a list of all EPs and EHs who qualified for an incentive payment on the basis of demonstrating that they are meaningful users of certified EHR technology. This query would also capture the provider type and practice location.</p> <p>Resources: MaineCare Services</p> <p>Proposed Technology to leverage: Maine OIT Developed System and other systems and sources</p>
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R-010-040: Populate aggregated data tables of AIU

Description:	<p>Description: MaineCare will query the data to populate aggregated data tables representing the provider adoption, implementation, or upgrade of certified EHR technology.</p> <p>Resources: MaineCare Services</p> <p>Proposed Technology to leverage: Maine OIT Developed System and other systems and sources</p>
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R-010-050: Populate aggregated data tables of clinical quality measures

Description:	<p>Description: MaineCare will query the data to populate aggregated data tables representing the clinical quality measures data collected by EPs and EHs.</p> <p>Resources: MaineCare Services</p> <p>Proposed Technology to leverage: Maine OIT Developed System and other systems and sources</p>
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R-010-060: Compile report on individuals with unique needs

Description:	<p>Description: MaineCare will query quantitative data showing how the incentive program addressed individuals with unique needs and will include a description of how the incentive program activities specifically include individuals with unique needs.</p> <p>Resources: MaineCare Services</p> <p>Proposed Technology to leverage: Maine OIT Developed System and other systems and sources</p>
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R-010-070: Compile annual CMS report

Description:	<p>Description: The HIT Manager compiles the information queried and the aggregated data tables into the annual report to CMS.</p> <p>Resources: HIT Manager</p> <p>Proposed Technology to leverage: Maine OIT Developed System and other systems and sources</p>
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R-010-080: Review annual CMS report

Description:	<p>Description: Upon completion of the annual CMS Report, relevant MaineCare and DHHS stakeholders will review the report for accuracy and integrity. Stakeholders include HIT Manager, OMS Director, Operations, DHHS Offices, OIT, Commissioner's Office, Office of the State Coordinator, and others as identified.</p> <p>Resources: MaineCare Leadership, OSC Director, HIT Program Manager Proposed Technology to leverage: None identified at this time</p>
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R-010-090: Approve annual CMS report

Description:	<p>Description: Stakeholders must approve the annual CMS report before it can be submitted to CMS.</p> <p>Resources: Stakeholders include HIT Manager, OMS Director, Operations, DHHS Offices, OIT, Commissioner's Office, Office of the State Coordinator, and others as identified.</p> <p>Proposed Technology to leverage: None identified at this time</p>
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R-010-100: Submit annual report to CMS

Description:	<p>Description: Once stakeholders review and approve the annual CMS report, the HIT Manager sends the report to CMS.</p> <p>Resources: MaineCare Leadership, HIT Program Manager</p> <p>Proposed Technology to leverage: None identified at this time</p>
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Events in this process:

P-030: Adjudicate Payment

P-010-020: Submit Attestation of AIU of EHR technology

P-010-030: Submit Attestation of Meaningful Use

Process: Submit Quarterly HHS Report Sub-Process**Tasks in this process:**

R-020-010: Compile quarterly HHS report

Description:	<p>Description: The HIT Program Manager will compile information on the EHR Incentive Program to submit a comprehensive report to HHS based on a variety of inputs. Some information used in the quarterly report may come from the monthly report submitted to CMS which reports on the administration of the program and use of FFP. Other inputs include reports of EP/EH payments, eligibility determination, audits, appeals, and other key management areas for the EHR Incentive Program. The report to HHS will provide a comprehensive overview of the State's EHR Incentive Program as well as a progress report on the implementation of the State's approved Medicaid HIT Plan.</p> <p>Resources: HIT Program Manager</p> <p>Proposed Technology to leverage: Maine OIT Developed System and other systems and sources</p>
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R-020-020: Review quarterly HHS report

Description:	<p>Description: Upon completion of the quarterly HHS Report, relevant MaineCare and DHHS stakeholders will review the report for accuracy and integrity. Stakeholders include HIT Manager, OMS Director, Operations, DHHS Offices, OIT, Commissioner's Office, Office of the State Coordinator, and others as identified.</p> <p>Resources: MaineCare Leadership, HIT Program Manager</p> <p>Proposed Technology to leverage: None identified at this time</p>
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R-020-030: Approve quarterly HHS report

Description:	<p>Description: Stakeholders must approve the quarterly HHS report before it can be submitted to HHS.</p> <p>Resources: Stakeholders include HIT Manager, OMS Director, Operations, DHHS Offices, OIT, Commissioner's Office, Office of the State Coordinator, and others as identified</p> <p>Proposed Technology to leverage: None identified at this time</p>
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R-020-040: Submit quarterly report to HHS

<p>Description:</p>	<p>Description: Once stakeholders review and approve the quarterly HHS report, the HIT Manager sends the quarterly report on the State's EHR Incentive Program and progress report on the implementation of the State's approved Medicaid HIT Plan to HHS.</p> <p>Resources: MaineCare Leadership, HIT Program Manager</p> <p>Proposed Technology to leverage: None identified at this time</p>
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Events in this process:

SOV-040: Track and report FFP for the Administration of Program

SOV-050: Manage FFP for Incentive Payments

SOV-020: Maintain SMHP

Process: Managing Provider Inquiries and Deliver Provider Education**Tasks in this Process**

COM-010-010: Contact Help Desk

Description:	<p>Description: The EP or EH has a question about the EHR Incentive Program and contacts the Help Desk via email or phone.</p> <p>Resources: OMS HIT Specialist</p> <p>Proposed Technology to leverage: None identified at this time</p>
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COM-010-020: Receive inquiry from EP/EH

Description:	<p>Description: The Help Desk receives inquiry from an EP or EH. Topics of inquiries might include EHR technology, technical assistance, incentive payments, attestation, and eligibility for Meaningful Use.</p> <p>Resources: OMS HIT Specialist</p> <p>Proposed Technology to leverage: Interactive Voice Response (IVR)</p>
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COM-010-030: Research Provider Inquiry

Description:	<p>Description: HIT Specialist researches the most current CMS Provider Inquiry Toolkit, MaineCare website, MaineCare rules, State Plan and other relevant rules, regulations, and guidelines. All inquiries unable to be answered by the HIT Specialist will be escalated to the OMS HIT Program Manager and/or CMS' EHR Information Center.</p> <p>Resources: OMS HIT Specialist / HIT Program Manager</p> <p>Proposed Technology to leverage: Web access and documents</p>
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COM-010-040: Respond to EP/EH with resolution

Description:	<p>Description: OMS HIT Specialist notifies EP/EH of resolution to their inquiry.</p> <p>Resources: OMS HIT Specialist / HIT Program Manager</p> <p>Proposed Technology to leverage: None identified at this time.</p>
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COM-010-050: Document Issue Resolution

Description:	<p>Description: HIT/EHR Incentive Program resource documents that the EP/EH inquiry has been resolved and closed.</p> <p>Resources: Help Desk</p> <p>Proposed Technology to leverage: None identified at this time.</p>
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Gateways in this process:

Inquiry received during Office Hours?

Events in this process:

Start

Description:	<p>Help desk receives a call or email from a provider with an inquiry regarding the EHR Incentive Program.</p>
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Process: Deliver Provider Education, Training, and Technical Assistance Sub-Process**Tasks in this process:**

COM-020-010: Create Education and Training Plan

Description:	<p>Description: Develop a training plan that includes a curriculum, content areas, targeted provider groups, schedule, and resource planning.</p> <p>Resources: HIT Program Manager, OMS Training Unit</p> <p>Proposed Technology to leverage: Training modules, teleconference and videoconference tools</p>
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COM-020-020: Develop Education and Training Materials

Description:	<p>Description: Develop training materials including training presentations, webinar content, user guides, quick-tip sheets, and train-the-trainer content, guides and materials,</p> <p>Resources: HIT Program Manager, OMS Training Unit</p> <p>Proposed Technology to leverage: Training modules, teleconference and videoconference tools and technology</p>
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COM-020-030: Conduct Provider Education and Training

Description:	<p>Description: This activity includes scheduling and conducting provider education and training sessions. For applicable audiences, OMS will deliver provider training. Provider satisfaction surveys will be completed to ascertain the effectiveness of the sessions.</p> <p>Resources: HIT Program Manager, OMS Training Unit</p> <p>Proposed Technology to leverage: Training modules, teleconference and videoconference tools and technology</p>
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Process: Deliver Provider Communications**Tasks in this process:**

COM-030-010: Create Communication Plan

Description:	<p>Description: MaineCare has developed a communication plan which includes the topic areas, frequency and schedule of communications, and distribution channels for communication.</p> <p>Resources: HIT Program Manager, MaineCare Director of Communications</p> <p>Proposed Technology to leverage: MaineCare website</p>
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COM-030-020: Develop Provider Communication Materials

Description:	<p>Description: In conjunction with the communication plan, MaineCare will continue to enhance provider communication's materials.</p> <p>Resources: HIT Program Manager, MaineCare Director of Communications</p> <p>Proposed Technology to leverage: MaineCare website</p>
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COM-030-030: Communications

Description:	<p>Description: MaineCare will send/deliver provider announcements and communications as outlined in the communication plan.</p> <p>Resources: HIT Program Manager, MaineCare Director of Communications</p> <p>Proposed Technology to leverage: MaineCare website</p>
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Process: Develop Rules**Tasks in this process:**

SOV-010-010: Receive request to add, delete, or change rule or state plan (NOTE: No State Plan Amendment is needed for the HIT Incentive Payment Program. SPA processes are just being included should an SPA be required at some time.)

Description:	<p>Description: Activity to add, delete, or change policies related to the EHR Incentive Payment Program initiated.</p> <p>Resources: Policy Division</p> <p>Proposed Technology to leverage: None identified at this time</p>
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SOV-010-020: Analyze rule or state plan

Description:	<p>Description: Information is requested to appropriately analyze the suggested policy addition, deletion, or revision. Assess impact of policy on budget, stakeholders, and other benefits.</p> <p>Resources: Policy Division, HIT Program Manager</p> <p>Proposed Technology to leverage: None identified at this time</p>
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SOV-010-030: Formulate, get approval, and propose rule

Description:	<p>Description: Policy Division drafts the rule that is being added, deleted or changed.</p> <p>Resources: Approvals are required from the HIT Program Manager, OMS Director, Operations, Commissioner's Office, and Attorney General's Office.</p> <p>Proposed Technology to leverage: None identified at this time</p>
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SOV-010-040: Hold Public Hearing (if recommended)

Description:	<p>Description: Follow Maine's APA and hold public hearing (if recommended) to review the proposed rule.</p> <p>Resources: Policy Division</p> <p>Proposed Technology to leverage: None identified at this time</p>
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SOV-010-050: Finalize rule and Respond to Public Comments

Description:	<p>Description: Finalize the rule based on outcomes from the public hearings, and respond to all public comments.</p> <p>Resources: Policy Division</p> <p>Proposed Technology to leverage: None identified at this time</p>
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SOV-010-060: Approve rule

Description:	<p>Description: Receive approvals from the State to execute the new rule.</p> <p>Resources: Policy Division, OMS Director, Commissioner's Office, Attorney General's Office, Secretary of State</p> <p>Proposed Technology to leverage: None identified at this time.</p>
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SOV-010-070: Publish the final rule

Description:	<p>Description: Publish the final rule per the APA.</p> <p>Resources: Policy Division, Director of Communications</p> <p>Proposed Technology to leverage: MaineCare website, DHHS website</p>
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SOV-010-080: Implement final rule

Description:	<p>Description: Develop plan for implementation of the new, changed, or deleted rule.</p> <p>Resources: Implementation done by the appropriate Program Office within DHHS, including Operations</p> <p>Proposed Technology to leverage: None identified at this time</p>
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Gateways in this process:

Is a rule needed?

Description:	Use the Maine APA process to adopt the rule.
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Process: Maintain SMHP

Tasks in this process:

SOV-020-010: Receive prompt to review SMHP

Description:	<p>Description: SMHP needs to be reviewed and updated on an annual basis. This activity is the prompt to review the SMHP.</p> <p>Resources: HIT Program Manager</p> <p>Proposed Technology to leverage: MIHMS, OIT Developed System, other systems as needed</p>
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SOV-020-060: Compile revised SMHP

Description:	<p>Description: This activity includes the compilation of the HIT Landscape Assessment, the HIT Vision, the Meaningful Use Sustainability Plan, and the Roadmap into the SMHP.</p> <p>Resources: HIT Program Manager</p> <p>Proposed Technology to leverage: MIHMS, OIT Developed System, other systems as needed</p>
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SOV-020-070: Disseminate SMHP for review

Description:	<p>Description: This activity is the distribution of the SMHP to relevant stakeholders for review and approval. Stakeholders include HIT Program Manager, OMS Director, Operations, DHHS Offices, OIT, Commissioner's Office, Office of the State Coordinator, and others as identified.</p> <p>Resources: HIT Program Manager</p> <p>Proposed Technology to leverage: MIHMS, OIT Developed System, other systems as needed</p>
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SOV-020-080: Modify SMHP Revisions

Description:	<p>Description: If stakeholders do not approve the revised SMHP, it must be modified to meet stakeholders' expectations. Upon modification, it will then go through the review process again.</p> <p>Resources: HIT Program Manager</p>
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	Proposed Technology to leverage: MIHMS, OIT Developed System, other systems as needed
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SOV-020-090: Submit SMHP to CMS for approval

Description:	<p>Description: CMS must approve the SMHP prior to any changes in the EHR Incentive Payment Program or request for additional funding to administer the EHR Incentive Payment Program.</p> <p>Resources: HIT Program Manager</p> <p>Proposed Technology to leverage: None identified at this time</p>
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SOV-020-100: Communicate revised SMHP

Description:	<p>Description: This activity is the final step in the Maintain SMHP process. The SMHP is published and distributed to all relevant stakeholders.</p> <p>Resources: HIT Program Manager, OMS Director of Communications</p> <p>Proposed Technology to leverage: HIT web page on MaineCare Services website</p>
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Gateways in this process:

Stakeholder approval received?

Description:	<p>Description: Stakeholders must approve the SMHP before it can be published and released as the updated SMHP. Stakeholders include HIT Program Manager, OMS Director, Operations, DHHS Offices, OIT, Commissioner's Office, Office of the State Coordinator, and others as identified.</p> <p>Resources: HIT Program Manager</p> <p>Proposed Technology to leverage: None identified at this time.</p>
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Events in this process:

SOV-030: Submit IAPD

Process: Revise HIT Landscape

Tasks in this process:

SOV-020-020-010: Review Current HIT Landscape Assessment

Description:	<p>Description: The HIT Landscape Assessment must be reviewed on an annual basis to understand if revisions need to be made to reflect the current HIT landscape in Maine.</p> <p>Resources: HIT Program Manager</p> <p>Proposed Technology to leverage: MIHMS, OIT Developed System, other systems as needed</p>
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SOV-020-020-020: Assess need for updates to HIT Landscape Assessment

Description:	<p>Description: This activity assesses the need for any revisions of the HIT Landscape Assessment specific to changes in the governance structure, DHHS systems changes, and DHHS and HIT initiatives.</p> <p>Resources: HIT Program Manager</p> <p>Proposed Technology to leverage: MIHMS, OIT Developed System, other systems as needed</p>
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SOV-020-020-030: Assess use of EHR technology

Description:	<p>Description: This activity includes surveying providers, hospitals, dentists, and other Eligible Professionals on adoption, implementation, and use of EHR technology.</p> <p>Resources: HIT Program Manager, Vendor</p> <p>Proposed Technology to leverage: MIHMS, OIT Developed System, other systems as needed, vendor systems</p>
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SOV-020-020-040: Document revisions and additions to HIT Landscape Assessment

Description:	<p>Description: This activity includes making revisions to the HIT Landscape Assessment based on the necessary updates in the previous two steps (changes in the state HIT environment and rates of EHR technology adoption).</p> <p>Resources: HIT Program Manager</p>
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	Proposed Technology to leverage: MIHMS, OIT Developed System, other systems as needed
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SOV-020-020-050: Disseminate HIT Landscape Assessment for review

Description:	<p>Description: This activity is the distribution of the HIT Landscape Assessment to relevant stakeholders for review and approval. Stakeholders include HIT Program Manager, OMS, OSC, Operations, OIT, and the Commissioner's Office.</p> <p>Resources: HIT Manager, Special Projects Unit</p> <p>Proposed Technology to leverage: None identified at this time</p>
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SOV-020-020-060: Modify HIT Landscape Assessment

Description:	<p>Description: If stakeholders do not approve the revised HIT Landscape Assessment, it must be modified to meet stakeholders' expectations. Upon modification, it will then go through the review process again.</p> <p>Resources: HIT Program Manager</p> <p>Proposed Technology to leverage: MIHMS, OIT Developed System, other systems as needed</p>
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Gateways in this process:

Stakeholder approval received?

Description:	<p>Description: Stakeholders must approve the HIT Landscape Assessment before it can be compiled with the revised SMHP.</p> <p>Resources: Stakeholders include OMS, HIT Program Manager, Operations, OIT, Commissioner's Office, OSC</p> <p>Proposed Technology to leverage: None identified at this time</p>
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Updates needed?

Description:	A decision should be made as to whether revisions and updates are needed to the HIT Landscape Assessment.
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Events in this process:

SOV-020-060: Compile revised SMHP

SOV-020-010: Receive prompt to review SMHP

Process: Revise Roadmap

Tasks in this process:

SOV-020-050-010: Review current HIT Roadmap

Description:	<p>Description: The HIT Roadmap must be reviewed on an annual basis to understand if MaineCare is making progress toward its HIT goals.</p> <p>Resources: HIT Program Manager</p> <p>Proposed Technology to leverage: MIHMS, OIT Developed System, other systems as needed</p>
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SOV-020-050-020: Track progress toward HIT Roadmap goals

Description:	<p>Description: This activity tracks current progress toward meeting milestones and accomplishing HIT goals set in the HIT Roadmap. The progress report will be completed quarterly.</p> <p>Resources: HIT Program Manager</p> <p>Proposed Technology to leverage: MIHMS, OIT Developed System, other systems as needed</p>
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SOV-020-050-030: Assess need for updates to HIT Roadmap

Description:	<p>Description: This activity assesses the need for any revisions of the HIT Roadmap based upon tracking progress toward accomplishing HIT goals.</p> <p>Resources: HIT Program Manager</p> <p>Proposed Technology to leverage: MIHMS, OIT Developed System, other systems as needed</p>
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SOV-020-050-040: Document revisions and additions to HIT Roadmap

Description:	<p>Description: This activity includes making revisions to the HIT Roadmap based on current progress toward achieving goals and milestones.</p> <p>Resources: HIT Program Manager</p> <p>Proposed Technology to leverage: MIHMS, OIT Developed System, other</p>
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	systems as needed
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SOV-020-050-050: Disseminate HIT Roadmap for review

Description:	<p>Description: This activity is the distribution of the HIT Roadmap to relevant stakeholders for review and approval. Stakeholders include HIT Program Manager, OMS, Operations, OIT, OSC, and the Commissioner's Office.</p> <p>Resources: HIT Program Manager</p> <p>Proposed Technology to leverage: None identified at this time</p>
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SOV-020-050-060: Modify HIT Roadmap

Description:	<p>Description: If stakeholders do not approve the revised HIT Roadmap, it must be modified to meet stakeholders' expectations. Upon modification, it will then go through the review process again.</p> <p>Resources: HIT Program Manager</p> <p>Proposed Technology to leverage: MIHMS, OIT Developed System, other systems as needed</p>
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Gateways in this process:

Stakeholder approval received?

Description:	<p>Description: Stakeholders must approve the HIT Roadmap before it can be compiled with the revised SMHP.</p> <p>Resources: Stakeholders include HIT Manager, OMS, Operations, OIT, Commissioner's Office, OSC</p> <p>Proposed Technology to leverage: None identified at this time</p>
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Updates needed?

Description:	A decision should be made as to whether revisions and updates are needed to the HIT Roadmap.
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Events in this process:

SOV-020-060: Compile revised SMHP

SOV-020-010: Receive prompt to review SMHP

Process: Submit IAPD Sub-Process

Tasks in this process:

SOV-030-010: Conduct annual review of EHR Incentive Program for modifications

<p>Description:</p>	<p>Description: The first activity in the IAPD submission sub-process is to assess the EHR Incentive Program for needed modifications, both on the program side and system side. This could include additional resources, training/education/outreach efforts, and/or systems modifications.</p> <p>If system modifications are required, all system modifications will go through the Change Control Board and follow the change request protocols and processes that are already in place and used by DHHS.</p> <p>Resources: MaineCare Leadership, HIT Program Manager</p> <p>Proposed Technology to leverage: None identified at this time</p>
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SOV-030-020: Develop business case for modifications

<p>Description:</p>	<p>Description: Once the needed program and system modifications are identified, the MaineCare Services and HIT team will need to develop a business case to ask for FFP from CMS for the needed modifications and enhancements.</p> <p>Resources: MaineCare Leadership, HIT Program Manager</p> <p>Proposed Technology to leverage: None identified at this time</p>
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SOV-030-030: Develop IAPD

<p>Description:</p>	<p>Description: Using the business case as a guide, MaineCare Services and the HIT team will develop the IAPD requesting FFP funding from CMS to fund EHR Incentive Program modifications and enhancements.</p> <p>Resources: MaineCare Leadership, HIT Program Manager</p> <p>Proposed Technology to leverage: None identified at this time</p>
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SOV-030-040: Review IAPD

<p>Description:</p>	<p>Description: Upon completion of the IAPD, relevant MaineCare and DHHS stakeholders will review the IAPD for accuracy and integrity. Stakeholders include HIT Program Manager, OMS Director, Operations, DHHS Offices, OIT, Commissioner's Office, Office of the State Coordinator, and others as identified.</p>
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	<p>Resources: MaineCare Leadership, HIT Program Manager, Special Projects Unit</p> <p>Proposed Technology to leverage: None identified at this time</p>
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SOV-030-050: Submit IAPD to CMS

Description:	<p>Description: Once stakeholders review and approve the IAPD, it is then submitted to CMS to request FFP funds.</p> <p>Resources: MaineCare Leadership, HIT Program Manager, Special Projects Unit</p> <p>Proposed Technology to leverage: None identified at this time</p>
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Gateways in this process:

Stakeholder approval received?

Description:	<p>Description: Stakeholders must approve the IAPD before it can be submitted to CMS.</p> <p>Resources: Stakeholders include HIT Program Manager, OMS Director, Operations, DHHS Offices, OIT, Commissioner's Office, Office of the State Coordinator, and others as identified.</p> <p>Proposed Technology to leverage: None identified at this time</p>
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Events in this process:

SOV-040-010: Receive approved IAPD from CMS

SOV-020: Maintain SMHP

Process: Track and Report FFP

Tasks in this process:

SOV-040-010: Receive approved IAPD from CMS

Description:	<p>Description: CMS approves the IAPD from MaineCare for the administration of the EHR Incentive Program.</p> <p>Resources: MaineCare Leadership, HIT Program Manager, Finance and Accounting</p> <p>Proposed Technology to leverage: None identified at this time</p>
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SOV-040-020: Follow Regular State budget process

Description:	<p>Description: MaineCare follows the State budget process to secure funds if needed for the administration of the EHR Incentive Program. MaineCare will estimate the expenditures for the Medicaid EHR Incentive Program on the quarterly budget estimate report via Form CMS-37, including projections of administration related expenditures for the implementation costs.</p> <p>Resources: MaineCare Leadership, HIT Program Manager, Finance and Accounting, Commissioner's Office, OIT, Governor's Office, Bureau of the Budget, Legislature</p> <p>Proposed Technology to leverage: BFMS (State Budget System) and AdvantageME</p>
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SOV-040-030: Process invoices for EHR Incentive Program Expenditures

Description:	<p>Description: Finance processes invoices for expenditures related to the administration of the EHR Incentive Program and HIT efforts. Invoiced expenditures include OIT expense, contractors' invoices/expenses, travel costs, and indirect costs. When an invoice is received, Finance reviews the account strings to apply the FFP funding and process the invoice.</p> <p>Resources: MaineCare Finance and Accounting</p> <p>Proposed Technology to leverage: AdvantageME</p>
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SOV-040-040: State Personnel report tie

Description:	Description: State employees record all time spent on HIT/EHR Incentive
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	<p>Program to the HIT project. Supervisors review and sign State employee timesheets to ensure that employees are charging their HIT time appropriately. Time is reported weekly and the pay period encompasses two weeks.</p> <p>Resources: State Personnel</p> <p>Proposed Technology to leverage: State time reporting system (TAMS)</p>
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SOV-040-050: Finance runs query

<p>Description:</p>	<p>Description: Finance runs a query to gather all data on expenditures for the administration of the EHR Incentive Program and HIT efforts. Expenditures include state personnel expense, OIT expense, contractors' invoices/expenses, travel costs, and indirect costs. This query occurs monthly.</p> <p>Resources: MaineCare Finance and Accounting</p> <p>Proposed Technology to leverage: State time reporting system (TAMS), GQL</p>
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SOV-040-060: Account for EHR Incentive Program Personnel Time

<p>Description:</p>	<p>Description: Finance and Accounting analyzes State Personnel time reporting and manually journals State Personnel time appropriately so that all personnel expenditures for the EHR Incentive Program are applied to the HIT/EHR Incentive Program account string/code and matched by ARRA funds at the rate of 90%.</p> <p>Resources: MaineCare Finance and Accounting</p> <p>Proposed Technology to leverage: State time reporting system (TAMS)</p>
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SOV-040-070: Draw down ARRA funds

<p>Description:</p>	<p>Description: Finance and Accounting uses the query of all EHR Incentive Program expenses to draw exactly 90% of the EHR Incentive Program expenses from the Federal Payment Management System.</p> <p>ARRA funds are drawn from the Federal Payment Management System monthly for State Personnel expenditures through the journal process. ARRA funds are drawn as invoices are received by Finance for the administration of the EHR Incentive Program. The invoice is then sent to</p>
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	<p>Accounts Payable for processing.</p> <p>Resources: MaineCare Finance and Accounting</p> <p>Proposed Technology to leverage: Medicaid Budget and Expenditure System, Federal Payment Management System</p>
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SOV-040-080: Compile monthly report

Description:	<p>Description: Finance and Accounting use the data from invoices and State personnel time journals to compile all EHR Incentive Program expenditures for the administration of the EHR Incentive Program and HIT efforts. Expenditures include State Personnel expense, OIT expense, contractors' invoices/expenses, travel costs, and indirect costs. The report of monthly expenditures for the Administration of the EHR Incentive Program is sent to the HIT Program Manager for insertion in the CMS monthly report. Furthermore, on the form CMS-64, which is submitted on a quarterly basis, MaineCare will report actual expenses incurred. This will be used to reconcile the Medicaid funding advanced to States for the quarter on the basis of the Form CMS-37.</p> <p>Resources: HIT Program Manager, Finance and Accounting</p> <p>Proposed Technology to leverage: Medicaid Budget and Expenditure System</p>
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SOV-040-090: Send Report to CMS

Description:	<p>Description: The HIT Program Manager sends the monthly report on the EHR Incentive Program to CMS which includes information on the expenditures that were paid using FFP from CMS.</p> <p>Resources: HIT Program Manager</p> <p>Proposed Technology to leverage: None identified at this time</p>
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Events in this process:

SOV-030-050: Submit IAPD to CMS

Process: Manage FFP for Providers**Tasks in this process:**

SOV-050-010: Reconcile payments

Description:	<p>Description: MaineCare reconciles the payment to the EP/EH with the payment from CMS verifying that 100% FFP match funding was received.</p> <p>Resources: Finance and Accounting</p> <p>Proposed Technology to leverage: AdvantageME, Medicaid Budget and Expenditure System</p>
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SOV-050-020: Compile monthly report

Description:	<p>Description: Finance and Operations manager run a query to gather all EHR Incentive Program Payments to EPs and EHs. This query occurs quarterly.</p> <p>The report of quarterly expenditures for EHR Incentive Program Payments to EPs and EHs is inserted in the CMS quarterly report.</p> <p>Resources: HIT Operations Manager, Finance and Accounting</p> <p>Proposed Technology to leverage: GQL, Medicaid Budget and Expenditure System</p>
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SOV-050-030: Send Report to CMS

Description:	<p>Description: The HIT Operations Manager sends the quarterly report on the EHR Incentive Program to CMS which includes information on the EHR incentive payments that were sent to EPs and EHs using 100% FFP from CMS.</p> <p>Resources: HIT Operations Manager</p> <p>Proposed Technology to leverage: None identified at this time.</p>
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Events in this process:

P-030: Adjudicate Payment

CMS SMHP Template Crosswalk

Question Number	CMS Guidance	Audit Strategy Report Section
1.	What will be the SMA's methods to be used to avoid making improper payments? (Timing, selection of which audit elements to examine pre or post-payment, use of proxy data, sampling, how the SMA will decide to focus audit efforts, etc.)	Section D
2.	Describe the methods the SMA will employ to identify suspected fraud and abuse, including noting if contractors will be used. Please identify what audit elements will be addressed through pre-payment controls or other methods and which audit elements will be addressed post-payment.	Section D
3.	How will the SMA track the total dollar amount of overpayments identified by the State as a result of oversight activities conducted during the FFY?	Section D
4.	Describe the actions the SMA will take when fraud and abuse is detected.	Section D
5.	Is the SMA planning to leverage existing data sources to verify meaningful use (e.g. HIEs, pharmacy hubs, immunization registries, public health surveillance databases, etc.)? Please describe.	Section D
6.	Will the state be using sampling as part of audit strategy? If yes, what sampling methodology will be performed?*(i.e. probe sampling, random sampling)	Section D
7.	**What methods will the SMA use to reduce provider burden and maintain integrity and efficacy of oversight process (e.g. above examples about leveraging existing data sources, piggy-backing on existing audit mechanisms/activities, etc.)?	Section D
8.	Where are the program integrity operations located within the State Medicaid Agency, and how will responsibility for EHR incentive payment oversight be allocated?	Section D

* The sampling methodology part of this question may be deferred until the State has formulated a methodology based upon the size of their EHR incentive payment recipient universe.

**May be deferred

CMS Crosswalk Questions

Question Number	CMS Guidance	The State's HIT Roadmap Section
1	*Provide CMS with a graphical as well as narrative pathway that clearly shows where the SMA is starting from (As-Is) today, where it expects to be five years from now (To-Be), and how it plans to get there.	Section E Part 7
2	What are the SMA's expectations re provider EHR technology adoption over time? Annual benchmarks by provider type?	Section E Part 7
3	Describe the annual benchmarks for each of the SMA's goals that will serve as clearly measurable indicators of progress along this scenario.	Section E Part 7
4	Discuss annual benchmarks for audit and oversight activities.	Section E Part 7